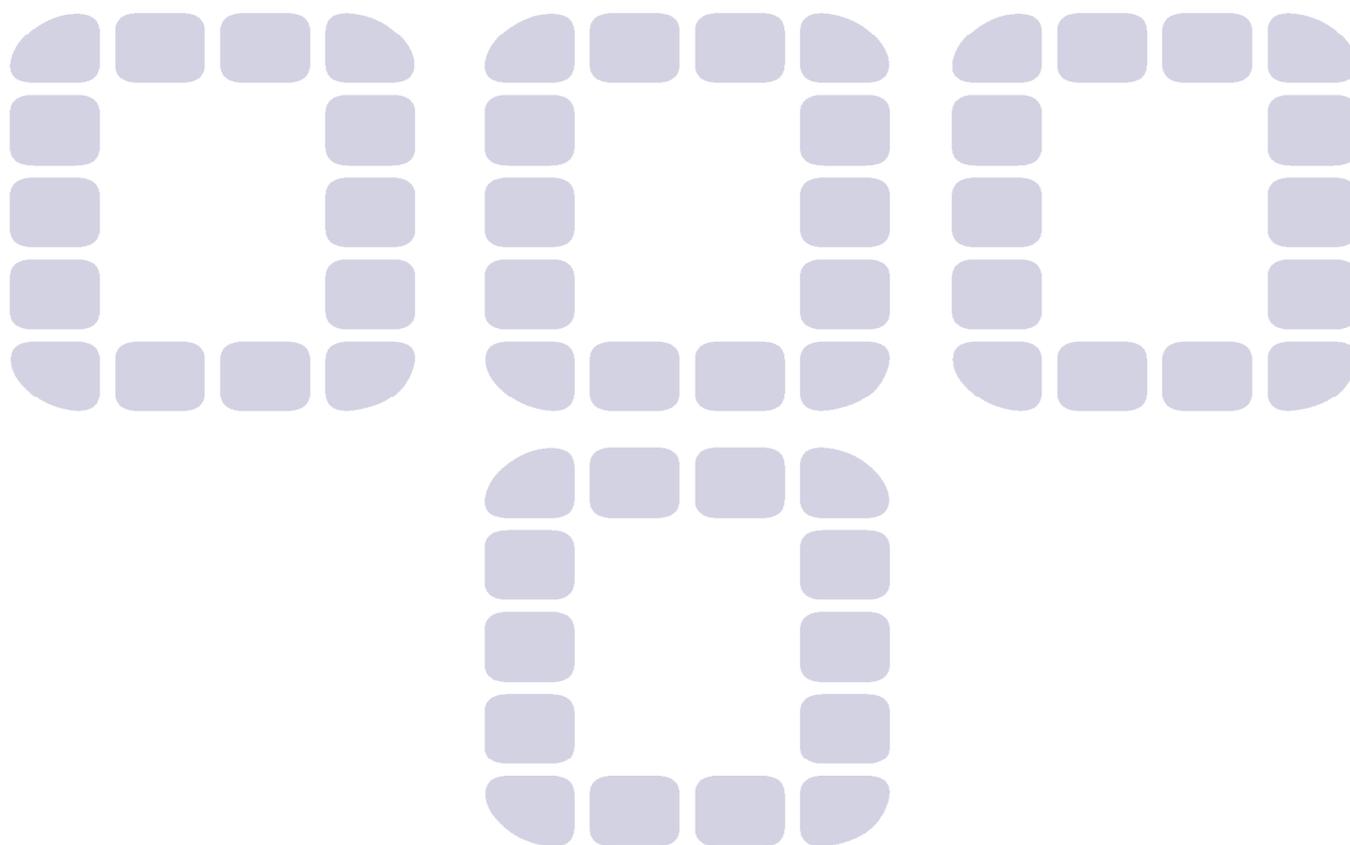


WA Country Health Service

Mental Health Strategic Intent: Strategic Framework for service planning to 2020



Government of **Western Australia**
Department of **Health**
WA Country Health Service

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1 Executive Summary

Delivery of mental health services to the rural and remote communities of Western Australia is a significant and costly challenge. To a large extent development of these services across WACHS has been opportunistic and ad-hoc with service planning occurring primarily at a regional level. National and State trends identify a need for consistent, quality mental health care to be available to all Western Australians.

The development of this paper represents an initial stage in aligning the planning and development of WACHS and other country mental health services with State and National planning over the next 10 years. It identifies key priority areas for service development across the continuum of care to address specific population needs and to inform more detailed service planning and development of area and regional service delivery models.

The following is a summary of the priority action areas for WACHS identified in this paper to address the future mental health needs of the country population and the future demand for services.

Immediate and Short Term (2010/2011):

Achievement of all these priorities within this time frame will be dependant upon resource availability.

- Commence development of comprehensive mental health service regional planning that aligns with the priorities of the 4th National Mental Health Plan and the WA State Strategic Policy and Plan (under development) and WACHS priorities and incorporates;
 - Review of emergency services and development of efficient and effective models to respond to mental health emergency presentations for all ages;
 - Review of inpatient care and alternate models of service delivery for all ages;
 - Renewed focus on community mental health services for all ages across the continuum of care.
- Commencement of detailed planning for State-wide Clinical Service Enhancement Program (SCSEP) to support the service development and priority areas that arise from the comprehensive mental health service plan.
- Establishment of the Aboriginal mental health service;
- Development of a policy direction for WACHS mental health services for dual diagnosis;
- Detailed service and workforce planning to improve availability of Infant Child Adolescent and Youth Mental Health Services (ICAYMHS).

Intermediate (2011-2013)

- Development of a comprehensive mental health workforce plan which will enable the delivery of the service plans and include:
 - Establishment of staffing benchmarks and targets;
 - Innovative attraction, recruitment and retention strategies that align with WACHS service delivery models;
 - Innovative workforce models;
 - Education and training for both the specialist mental health workforce and the general workforce, including supervision and support.

- Evaluation of older adult subacute care program to inform further service and workforce planning to ensure the needs of the older adult population can be met by 2020;
- Implementation of service delivery models for emergency mental health services;
- Development of service delivery models and strategies to address gaps in early intervention and rehabilitation services;
- Implementation of ongoing training in the input and utilisation of mental health data to inform patient care and service planning;

Long term (2013 onwards)

- Implementation of workforce plan and actions;
- Implementation of planning recommendations for ICAYMHS services;
- Development and implementation of a sustainable model for providing older adult mental health services;
- Implementation of SCSEP development plan.
- Implementation of WACHS specific research and evaluation programs;
- Implementation of service delivery models and strategies to address service delivery gaps in early intervention and rehabilitation.

2 Introduction

The WA Country Health Service (WACHS) is the largest country health system in Australia and one of the biggest in the world. It covers an area of some 2.5 million square kilometres with an estimated population of 528,000 people.

“In general the prevalence of mental health conditions in rural and remote Australia has been estimated as equivalent to levels in major cities. However rural Australians face greater challenges as a result of such conditions, due both to the difficulty of accessing the support needed for mental illness and to the greater visibility and stigma...”¹

Rural and remote communities face higher exposure to risk of mental illness or psychological distress due to such factors as financial uncertainty, social isolation, high levels of unemployment, poor access to housing, social and other services, higher incidence of death or disability related to trauma (e.g. motor vehicle accidents and drowning). Despite this WACHS has traditionally received considerably less (approximately 10%) of total mental health funding in WA for (approximately) 27% of the population.

Delivery of mental health services to the rural and remote communities of Western Australia is a significant and costly challenge.

2.1 Purpose of this document

The Commonwealth (Fourth National Mental Health Plan, 2009 - 2014) and State governments (Mental Health Policy and Plan 2010-2020; in draft) and the WA Country Health Service Strategic Plan (Re-vitalising The WA Country Health Service 2009 - 2012) state broad priorities for mental health. This paper aims to link these priorities to a framework to inform MH services planning in WACHS over the next decade.

Key Objectives

- To describe the current model and range of mental health services and facilities provided by WACHS and other health providers across the spectrum of care;
- To inform key stakeholders and service planners of strategies and priorities for country mental health services;
- To identify priority areas for action based on evidence of need and demand;
- To describe key principles for:
 - Development of models of care;
 - Service planning over the next ten years.
- To describe the WACHS relationship with the Mental Health Commission.

¹ The National Rural Health Alliance: Fact Sheet 18: Mental Health in Rural Australia. May 2009

3 Background

3.1 National Context

Since 1992 successive National Mental Health Policies and Plans have guided the National Mental Health Strategy leading reform of mental health services across Australia. The most recent Policy (2008) “...recognises that attention to [mental health] promotion, prevention, and early intervention across the life span will benefit the whole community... the need for collaboration across a range of services provided or funded by different government and private sectors, non-government agencies, individuals and organisations in the community to improve the mental health of Australians.

Most importantly... to achieve the desired outcomes there must be ongoing development and support of a skilled workforce delivering quality services that are based on the best evidence and are continually monitored and evaluated... mutual respect, respect and responsibility are required to close the gap on Indigenous disadvantage and to improve [Indigenous] mental health and well-being.”

The Fourth National Mental Health Plan - *An agenda for collaborative government action in mental health 2009–2014* identifies five priority areas;

- Social inclusion and recovery;
- Prevention and early intervention;
- Service access, coordination and continuity of care;
- Quality improvement and innovation;
- Accountability- measuring and reporting success.

Other key national documents are included in Appendix 3.

3.2 State Context

In recent years there has not been an overarching state-wide mental health strategic plan however there have been some targeted state government funded strategies (refer Appendix 3).

In 2008 the Western Australian Government established Australia’s first Minister for Mental Health (the Minister) and in 2009 appointed a Mental Health Commissioner (The Commissioner). The Commissioner is leading the development of a State Policy and Plan for 2010-2020. The Commissioner will hold responsibility for promoting collaborative partnership approaches to mental health care via planning and policy development and purchasing of services.

An outcome of the establishment of the Mental Health Commission has been the need for Area Health Services to work together to coordinate service delivery resulting in the reformation of the Mental Health Operations Review Committee (MHORC). Improved consistency in and coordination of mental health services across the state has also been highlighted by the review of Adult Community Mental Health Teams by the Office of the Auditor General (OAG).

In 2010 WA Health published its new Clinical Services Framework, 2010 - 2020 (the CSF) which describes the current and future role delineation for health and hospital services including mental health services for all WACHS’ Regional and District hospitals. In this document it is proposed that all WACHS’ regional hospitals except

the Pilbara will have role delineation as a Level 5 adult inpatient mental health service by either 2014/15 or 2020/21. Child and Adolescent inpatient mental health services will still be provided in Perth for the foreseeable future.

Level 5 role delineation is described in the CSF as an authorised inpatient mental health treatment with comprehensive multi-disciplinary team routinely available on site and on call 24/7 with limited consultation and liaison services to general wards. The CSF also proposed that its larger district hospitals and Port Hedland regional hospital would provide level four non-authorised inpatient mental health services with multi-disciplinary staff on call 24/7 by 2014/15.

3.3 WA Country Health Service

The past 10 years have seen significant organisational reform of health services in rural and remote regions of Western Australia. From 42 separate and independent statutory health authorities, controlled by local Boards of management there is now a single, unified and strengthened country health system with accountability and governance structured across seven regions:

- Kimberley;
- Pilbara;
- Midwest;
- Wheatbelt;
- Goldfields;
- South West;
- Great Southern.

In March 2006 the WACHS Area Director, Mental Health was appointed to provide:

- Assistance, support and advice to the WACHS CEO and other key directors and managers on mental health issues;
- Policy development;
- Co-ordination of mental health service delivery across WACHS;
- Facilitation of linkages and collaboration between WACHS, the mental health sector and other services and agencies involved in mental health care;
- WACHS representation on state-wide committees related to mental health.

Re-Vitalising The WA Country Health Service 2009-2012

The WA Country Health Service strategic plan (Re-vitalising) identifies four broad objectives for the next five years:

- A fair share for country health: *Securing a fair share of resources and being accountable for their use;*
- Service delivery according to need: *Improving service access based on need and improving health outcomes;*
- Closing the gap to improve Aboriginal health: *Improving the health of Aboriginal people;*
- Workforce stability and excellence: *Building a skilled workforce and a supportive workplace.*

One of 13 key actions in Revitalising is to link alcohol, drug and mental health services and to strengthen mental health promotion and illness prevention.

4 WACHS Mental Health and Activity Profile

This section outlines the population of WACHS, mental health activity, morbidity (diagnosis) for inpatients, community activity, and causes of death. This data informs the priority mental health issues to be focussed on for future services planning.

4.1 Population and Projections

The need for mental health services in Australia is well recognized as approximately one in five people experience mental health issues in any one year.

Table 1 : WACHS Population by Region

	2006 (Census)	2011 Estimated	2016 Estimated	2021 Estimated	% change 2006 - 2021	Average growth per year
Goldfields	55,604	62,214	65,825	69,630	25.2%	1.5%
Great Southern	55,448	60,545	64,810	68,805	24.1%	1.4%
Kimberley	33,005	47,322	55,492	63,959	93.8%	4.5%
Midwest	61,328	68,266	72,138	75,925	23.8%	1.4%
Pilbara	44,333	46,994	50,570	53,486	20.6%	1.3%
South West	141,677	162,369	178,826	193,978	36.9%	2.1%
Wheatbelt	73,490	80,166	87,080	94,225	28.2%	1.7%
Grand Total	464,885	527,876	574,741	620,008	33.4%	1.9%

Source: ABS Population Projections Series B+

Table 2 : WACHS population growth to 2021 by age groupings

	2009 Estimated	2011 Estimated	2016 Estimated	2021 Estimated	% change 2009 and 2021	Average growth per year
00 to 14 yrs	113,755	116,380	123,900	131,529	15.6%	1.2%
15 o 64 yrs	339,777	351,042	374,416	394,203	16.0%	1.2%
65 yrs and over	55,818	60,455	76,425	94,276	68.9%	4.5%
Grand Total	509,350	527,876	574,741	620,008	21.7%	1.7%

Source: ABS Series B+ projections

Implications for Service Planning

The increasing population in all WACHS regions will require more mental health services across WACHS over the next 10 years, particularly in services for older adults given that the population over 65 is projected to increase at 3.7 times the rate of other age groupings. The types of mental health services required into the future (eg more community mental health services, step down services, inpatient, early intervention, prevention etc) is dependent on policy directions, evidence of best and effective practice and informed by analysis of mental health service activity.

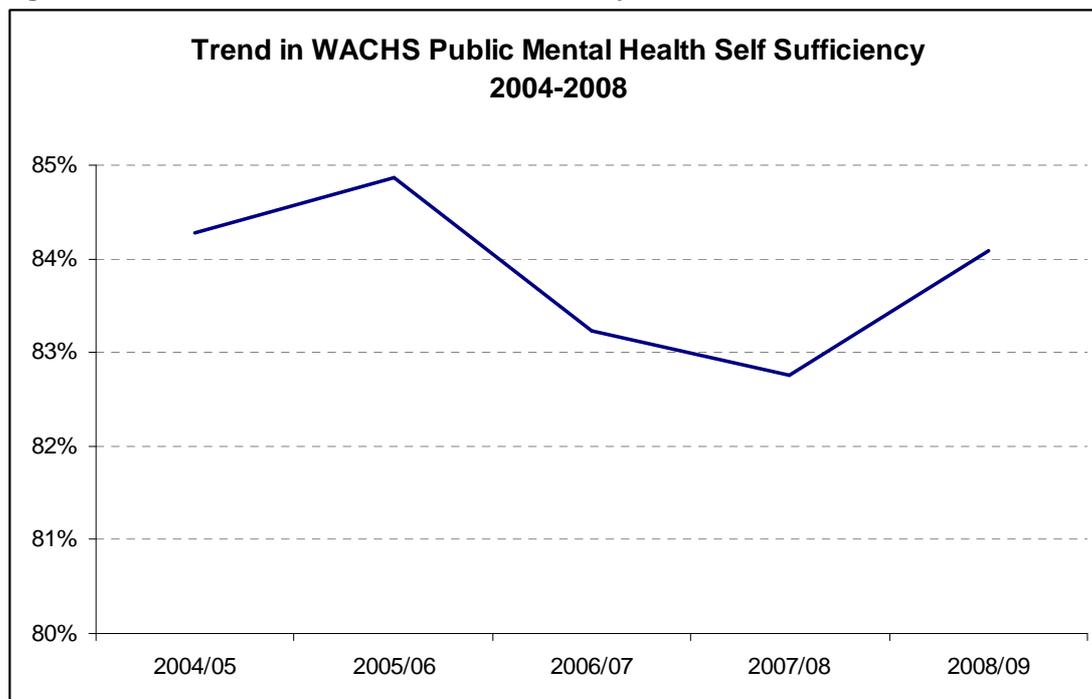
4.2 Inpatient Mental Health Activity

4.2.1 WACHS' capacity to treat its own country residents

Self sufficiency is a measure of how much treatment WACHS provides for its own residents in comparison to WACHS residents needing to travel to Perth for treatment. For example, if a region has 70% inpatient self sufficiency this means that the 70% of the mental health hospital admissions needed by the local residents occur in the region and 30% of the admissions occur in Perth or interstate hospitals – generally the people needing more complex treatments.

WACHS inpatient self sufficiency in mental health has averaged 83% over the last five years which is high overall. The WACHS is planning to build two more Acute Psychiatric Units (APU) in Broome serving both Kimberley and Pilbara residents (currently under construction) and Geraldton. This will increase WACHS' ability to care for more mental health patients locally (ie increase WACHS' mental health self sufficiency) though difficulties in attracting and retaining a specialist mental health workforce in regional areas in WA may impede this goal.

Figure 1: Trend in WACHS Public Self Sufficiency, 2004/05-2008/09



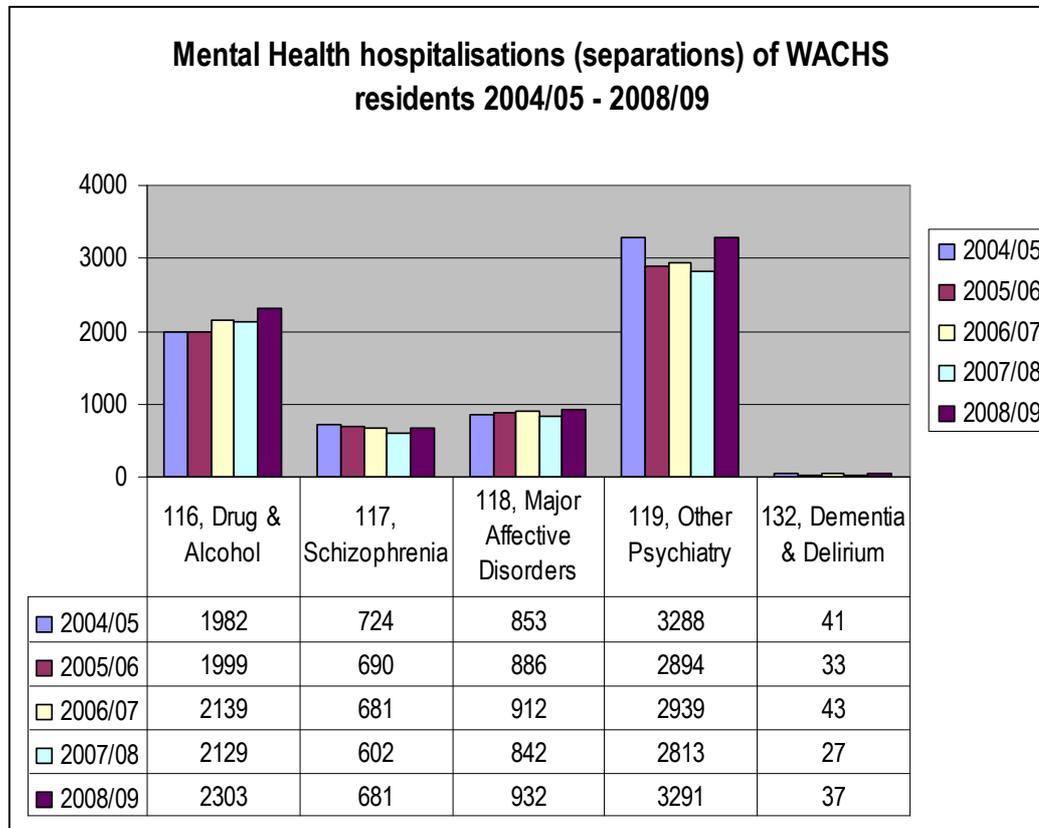
Source: HMDS data via WACHS online Rural Demand pivot - excludes private separations

4.2.2 Inpatient Mental Health Trends by Diagnosis (Morbidity)

In this section, activity is presented as admissions to hospital. The historical trends for inpatient mental health admissions by WACHS residents between 2004/05 and 2008/09 are summarised and grouped below. The grouping of 'other psychiatry' which includes anxiety, eating, somatoform and personality disorders accounts for 45% of all hospital admissions, and drug and alcohol accounts for 31% of all hospital admissions residents. Admissions of WACHS residents for major affective disorders (e.g. clinical depression) accounts for 14% of admissions. There is possibly an error in coding of dementia patients as some patients may be coded as 'Nursing Home' patients so the figures below could be an undercount.

It should be noted that this data is for the primary (main) diagnosis and does not reflect the other mental or physical health issues (co-morbidities) that many mental health clients suffer. For example it is generally considered that up to 80% of people with mental health problems can also suffer from alcohol or other drug issues.

Figure 2: Inpatient Mental Health Admissions of WACHS Residents 2004/05 – 2008/09



Diagnosis uses Expanded Service Related Groups

Source: HMDS data, from the WACHS Rural Inpatient Demand Online Pivot accessed on 18/8/2010

4.2.3 Average Length of Stay

The average length of stay in hospital for WACHS mental health patients during 2003 – 2008 was around four days for people diagnosed under the other psychiatry category and just less than three days for people who are diagnosed with a drug and alcohol issue. Major affective disorders (e.g. clinical depression) had an average length of stay of 12 days and for schizophrenia it was around 18 days, longer in recent years with 21.5 days in 2007/08.

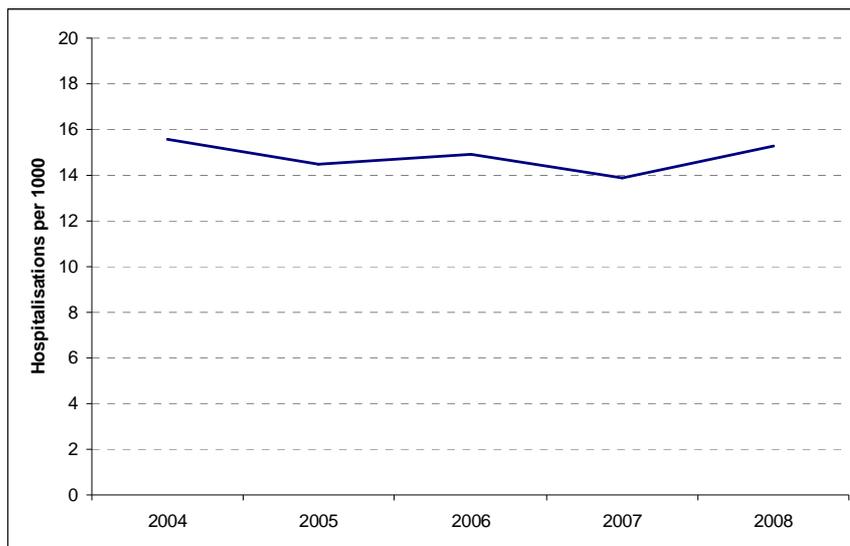
Implications for Service Planning

While there will always be some people who require inpatient admissions for an acute exacerbation of their mental health issues, increased community mental health services will be able support more people in the community and reduce or prevent hospital admissions even further. If these services were to have a greater capacity to intervene early and there were more 'step down' facilities when someone has an acute exacerbation it is likely that the average length of stay in hospital could be reduced and people could recover more quickly.

4.2.4 Mental Health Hospitalisation Rates for WACHS Residents

The average rate of hospitalisation of WACHS residents for mental health conditions between 2003/04 and 2008/09 was 15 admissions per 1,000 population. The graph below shows the trend in the rates of hospitalisation of WACHS residents during this period. It shows the rate of admission has remained relatively steady with an average 4% decrease over the first four years but with a 10% increase in the last year.

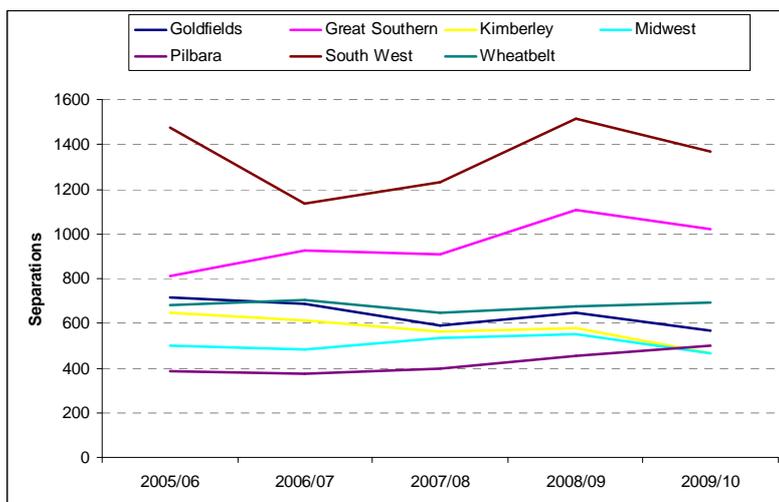
Figure 3: Rates of Mental Health Hospitalisations of WACHS Residents



Source: HMDS data, from the Rural Inpatient Demand Online Pivot accessed on 4/8/2010

4.2.5 Mental Health Activity in WACHS Hospitals

Figure 4: Mental Health Hospitalisations by Region 2005/06- 2009/10



Source: ATS detail pivot via data warehouse for selected ESRGs 116,117,118,119 and 132. Accessed 20/08/2010.

Across the whole of WACHS there was no discernable trend in the number of admissions (these numbers includes visitors to the regions not just WACHS)

residents). Some regions showed increases and some showed decreases. Goldfields and Kimberley showed decreasing hospital admissions while Great Southern and Pilbara showed increases.

WACHS Acute Psychiatric Units

There are currently three dedicated acute psychiatric units in Bunbury, Albany and Kalgoorlie. Albany has 9 active beds, Kalgoorlie has 7 and Bunbury had 15 in 2005 and 2006 which reduced to 11 in 2007 and increased to 27 from 2008. Bed occupancy in each of the acute psychiatric wards has decreased from 2007.

Table 3: Acute Psychiatric Ward Bed Occupancy, 2005 – 2009

	Albany	Bunbury	Kalgoorlie
2005	83.2%	69.2%	62.9%
2006	76.9%	69.0%	65.8%
2007	92.0%	66.7%	80.5%
2008	86.5%	59.1%	72.1%
2009	81.7%	58.4%	58.8%

Goldfields

Approximately thirty nine percent of mental health admissions in the Goldfields are treated in the specialised psychiatric unit in Kalgoorlie while the others are treated in general wards in Kalgoorlie and other hospitals in the region.

Table 4: Inpatient Mental Health Goldfields 2005 – 2009

Year	Psychiatric ward (Kalgoorlie)		Non psychiatric ward (region)		Total
	Number	Percentage	Number	Percentage	
2005	279	41.5%	394	58.5%	673
2006	293	41.3%	416	58.7%	709
2007	264	41.5%	372	58.5%	636
2008	214	33.5%	425	66.5%	639
2009	239	36.3%	419	63.7%	658
	1289	38.9%	2026	61.1%	3315

Data source: HMDS Morbidity Mental Health

Table 5: Inpatient Mental Health, Kalgoorlie Specialised Mental Health and General Ward, 2005 – 2009

Year	Psychiatric ward (specialised unit)		Non psychiatric ward (general ward)		Total
	Number	Percentage	Number	Percentage	
2005	279	64.3%	155	35.7%	434
2006	293	62.9%	173	37.1%	466
2007	264	62.9%	156	37.1%	420
2008	214	54.3%	180	45.7%	394
2009	239	60.5%	156	39.5%	395
	1289	61.1%	820	38.9%	2109

Data source: HMDS Morbidity Mental Health

Just under two thirds (61%) of mental health admissions in Kalgoorlie were to the specialised unit. The trend in admissions is relatively steady over the five year period.

Great Southern

Less than twenty five percent of mental health admissions in the Great Southern region are treated in the specialised psychiatric unit in Albany while the others are treated in general wards in Albany and other hospitals in the region.

Table 6: Inpatient Mental Health Great Southern 2005 – 2009

Year	Psychiatric ward (Albany)		Non psychiatric ward (region)		Total
	Number	Percentage	Number	Percentage	
2005	187	20.6%	721	79.4%	908
2006	222	24.0%	704	76.0%	926
2007	209	22.5%	718	77.5%	927
2008	261	24.8%	793	75.2%	1054
2009	249	21.4%	913	78.6%	1162
	1128	22.7%	3849	77.3%	4977

Data source: HMDS Morbidity Mental Health

Table 7: Inpatient Mental Health Albany Specialised Mental Health and General Ward, 2005– 2009

Year	Psychiatric ward (specialised unit)		Non psychiatric ward (general ward)		Total
	Number	Percentage	Number	Percentage	
2005	187	26.4%	521	73.6%	708
2006	222	30.0%	519	70.0%	741
2007	209	29.9%	490	70.1%	699
2008	261	33.7%	514	66.3%	775
2009	249	27.0%	673	73.0%	922
	1128	29.3%	2717	70.7%	3845

Data source: HMDS Morbidity Mental Health

Less than one third (29%) of mental health admissions in Albany are to the specialised unit and the remainder to the general wards. This will change when the 16 bed unit is built on the new Albany Health Campus, due for completion in 13/14.

While the numbers of mental health admissions to the Albany hospital have increased by 30% over the past four years, there has been a 33% increase in admissions to the specialised unit in the same period.

South West

In the South West twenty eight (28%) per cent of mental health admissions are treated in the specialised psychiatric unit in Bunbury while the others are treated in general wards in Bunbury and other hospitals in the region.

Table 8: Inpatient Mental Health

Year	Psychiatric ward (Bunbury)		Non psychiatric ward (region)		Total
	Number	Percentage	Number	Percentage	
2005	406	26.4%	1129	73.6%	1535
2006	387	26.9%	1050	73.1%	1437
2007	265	20.4%	1031	79.6%	1296
2008	475	31.9%	1015	68.1%	1490
2009	497	33.0%	1010	67.0%	1507
	2030	27.9%	5235	72.1%	7265

Data source: HMDS Morbidity Mental Health

Table 9: Inpatient Mental Health, for Bunbury Specialised Mental Health and General Ward, 2005-2009

Year	Psychiatric ward (specialised unit)		Non psychiatric ward (general ward)		Total
	Number	Percentage	Number	Percentage	
2005	406	54.9%	334	45.1%	740
2006	387	54.1%	329	45.9%	716
2007	265	41.5%	374	58.5%	639
2008	475	61.0%	304	39.0%	779
2009	497	59.4%	340	40.6%	837
	2030	54.7%	1681	45.3%	3711

Data source: HMDS Morbidity Mental Health

Since the opening of the Bunbury psychiatric unit there has been an increasing trend for mental health admissions to be to this unit and by 2009 approximately three in five of all mental health admissions were to the unit with the remaining admissions to Bunbury's general medical wards.

Aboriginal and Torres Strait Islander Inpatient Admissions

While only 7% of WACHS residents are Aboriginal or Torres Strait Islander (ATSI), 19.5% of all WACHS mental health patients identified themselves as ATSI between 2003 and 2007. It should be noted that self identification can lead to an undercount so these figures may be under-representing ATSI admissions.

For the older adults age group (over 45 for ATSI people and over 65 for Non-ATSI people) 30% of mental health admissions were for ATSI patients during that period.

Table 10: WACHS Resident Inpatient Mental Health Activity Aboriginal/Non-Aboriginal by Age Group, 2003-2007

Age Group	ATSI	% of ATSI	Non- ATSI	% of Non ATSI	Proportion of total population
Children 0-14	330	5.0%	1,674	6.2%	6%
Adolescents & Adults 15-44 (ATSI)	5,192	79%	22,879	85%	84%
15-64 (Non-ATSI)					
Older Adults 45+ (ATSI)	1,030	16%	2,450	9%	10%
65+ (Non-ATSI)					
Total	6,552		27,003		

Source: HMDS data, from the Rural Inpatient Demand Online Pivot accessed on 4/8/2010: ATSI = Aboriginal and Torres Strait Islander

Implications for Services Planning

There have been minimal changes to the numbers and rates per 1,000 WACHS residents of admission for mental health conditions to WACHS hospitals over the past few years – despite a country population that is increasing by around 1.9% per year overall and up to 4.5% in the Kimberley. These trends indicate that admissions are being prevented by community mental health and primary care services and more people are being supported in the community. This is supported in section 4.4 which demonstrates that community mental health service activity has been steadily increasing across WACHS.

The importance of enhancing services for addressing drug and alcohol and co-morbidity issues is clearly demonstrated given that around one third of admissions are for these issues.

Most hospitalisations (45%) are for non psychotic and non major affective disorders. More community mental health, 'step down' or access to specialist services could potentially reduce these admissions and the average length of stay.

The focus on Aboriginal Mental Health is clearly supported given that one fifth of mental health clients identify themselves as Aboriginal. This increases to 30% of mental health presentations for older adults (i.e. Aboriginal people over 45). In the Kimberley region Aboriginal mental health is core business.

Older adults have formed only 10% of mental health presentations in recent years however this will increase as the proportion of older adults (65+) increases over the next 10 years at 3.7 times the rate of other age groups (Table 2, page 10). This rate might actually be greater than this as ATSI people are regarded as aged when over 45 years.

Further analysis to determine where regional residents are admitted and for what reasons now and into the future would be an important guide to considering both the inpatient and community mental health services required and their locations into the future.

Inpatient Mental Health Activity Projections

Inpatient activity projections were developed by WA Health in 2010 using the Australian Inpatient Modelling tool. These project forward the historical trend of the seven years to 2007/08 and incorporate population projections from the Australian Bureau of Statistics (ABS Series B+). The projections are a guide to future activity in WACHS hospitals and indicate an increase in mental health inpatient activity (excluding dementia) between 2007 and 2021 of 26% which represents an average annual growth of 1.7%.

4.3 Emergency Presentations

Between 2008/09 and 2009/10 16,307 presentations to emergency departments (ED) were for mental health or alcohol and drug issues. This is 2% of all ED presentations in WACHS. Presentations to EDs have been increasing at an average annual rate of 4% and are projected by the Department of Health's clinical modelling unit to increase in WACHS at an average annual rate of 3.5% to 2021.

Kimberley has had the greatest increase in mental health ED presentations with an average of 11% each year whereas the South West has not recorded an increase in mental health ED presentations in recent years. This may be due to data recording issues which need to be addressed.

Around three quarters of all ED presentations are classified as non urgent compared to only half of those classified as mental health related. Of the mental health presentations to ED 37% are admitted, 25% treated and referred to GP, 23% are treated and not referred on. Just over half of all mental health presentations to ED are female and almost a quarter of mental health presentations to ED are Aboriginal. Almost three quarters of mental health presentations to ED are aged 15-44.

The data shows that 41% of mental health presentations to ED are in ED for less than an hour and 94% of mental health presentations to ED are in ED for less than 4 hours.

Implications for Services Planning

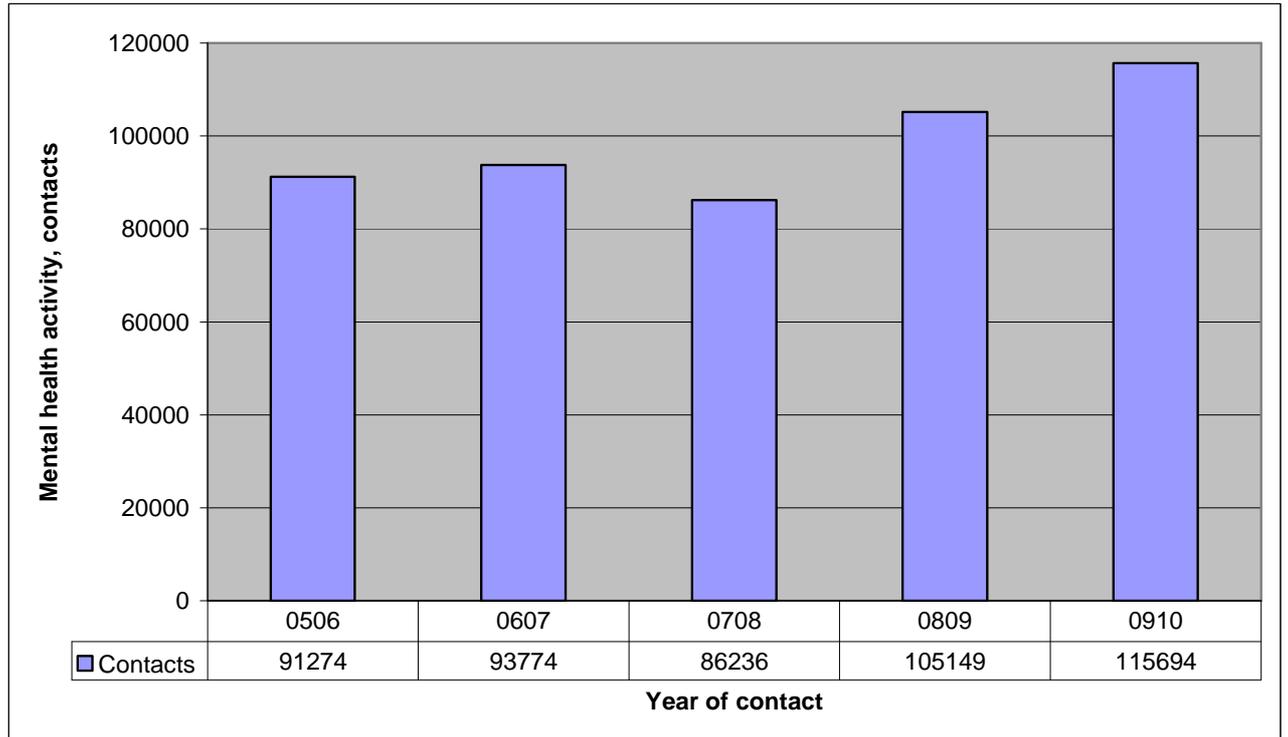
Given the relatively low numbers and the time of day presentations occur (often after hours) a single service model to support mental health presentations to EDs might not be appropriate. This needs careful consideration.

4.4 Community (Ambulatory) Mental Health Activity

This section refers to mental health contacts in all WACHS services for any clients.

An increasing level of community mental health activity is seen in WACHS over the 5 years. The exception to this is a downward trend seen from 2006 to 2007.

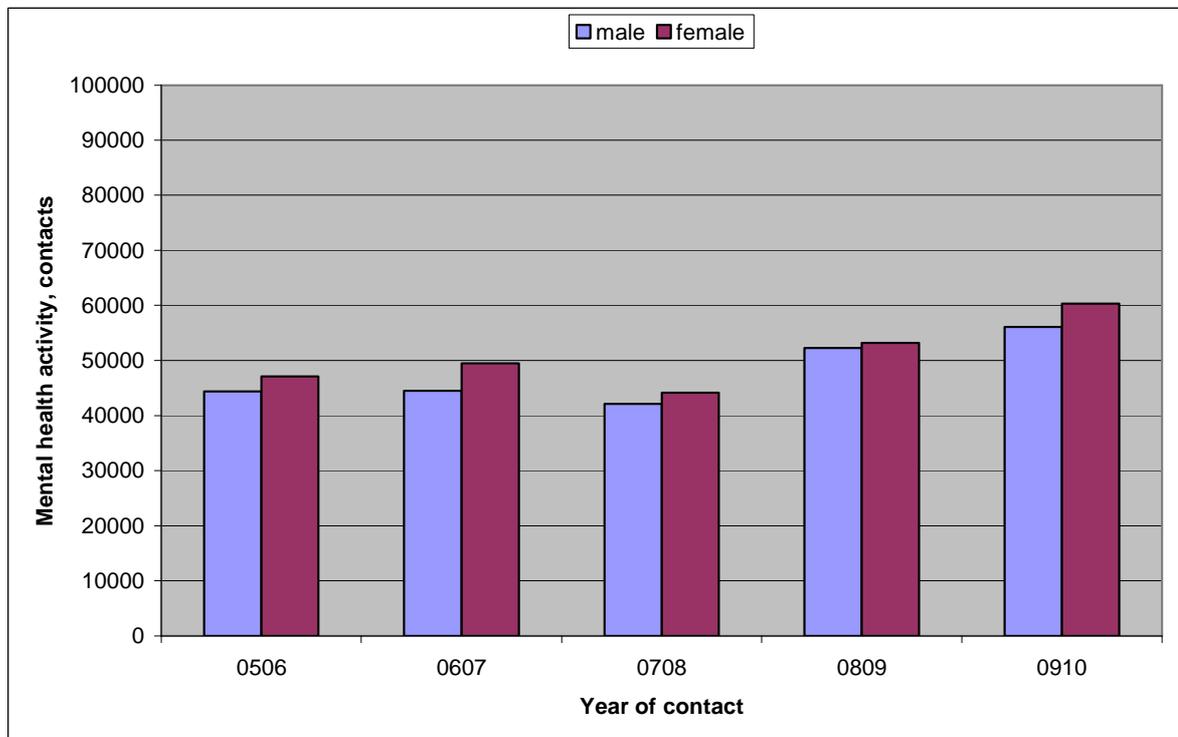
Figure 5: WACHS Community Mental Health Activity by financial year 2005/06-2009/10



Source: MHIS

Overall there is an increasing trend in Community Mental Health Activity with more occasions of services for women than men.

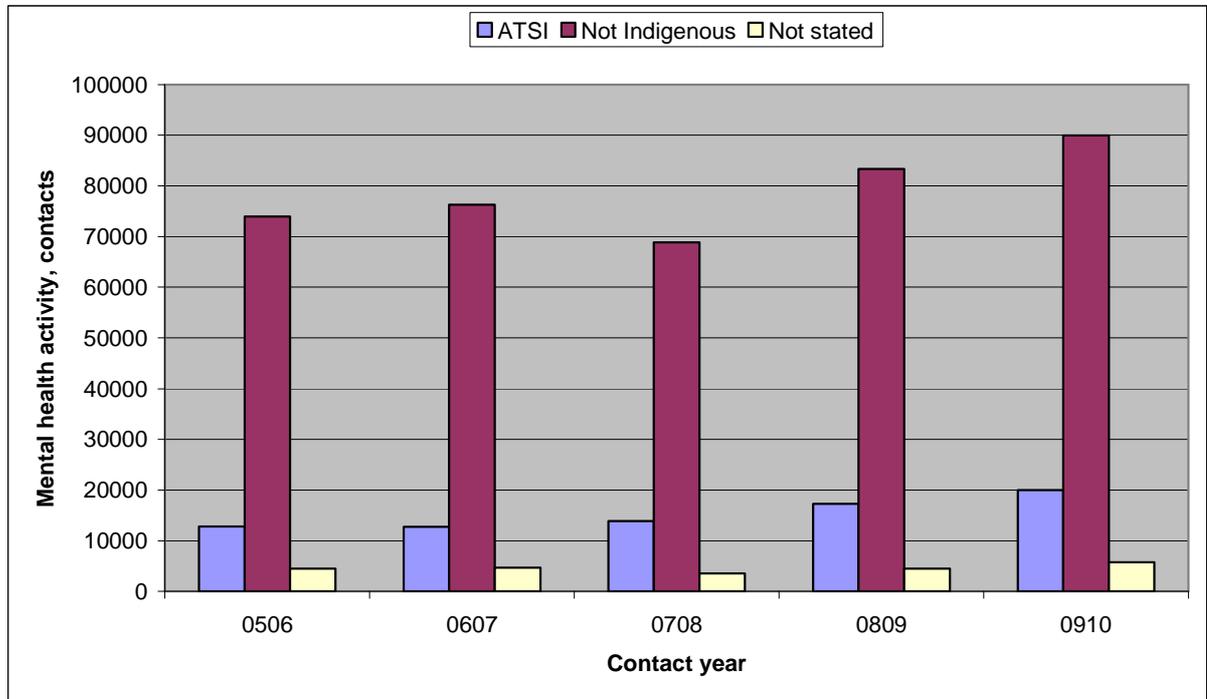
Figure 6: WACHS Community Mental Health Activity by financial year, 2005/06-2009/10 by Gender



Source: MHIS; total 27 missing gender

There is an increasing trend in the provision of community mental health services to ATSI people in WACHS. The number of services where Aboriginality is not recorded should be noted. In addition there is a recognised undercount of Aboriginal people throughout WACHS.

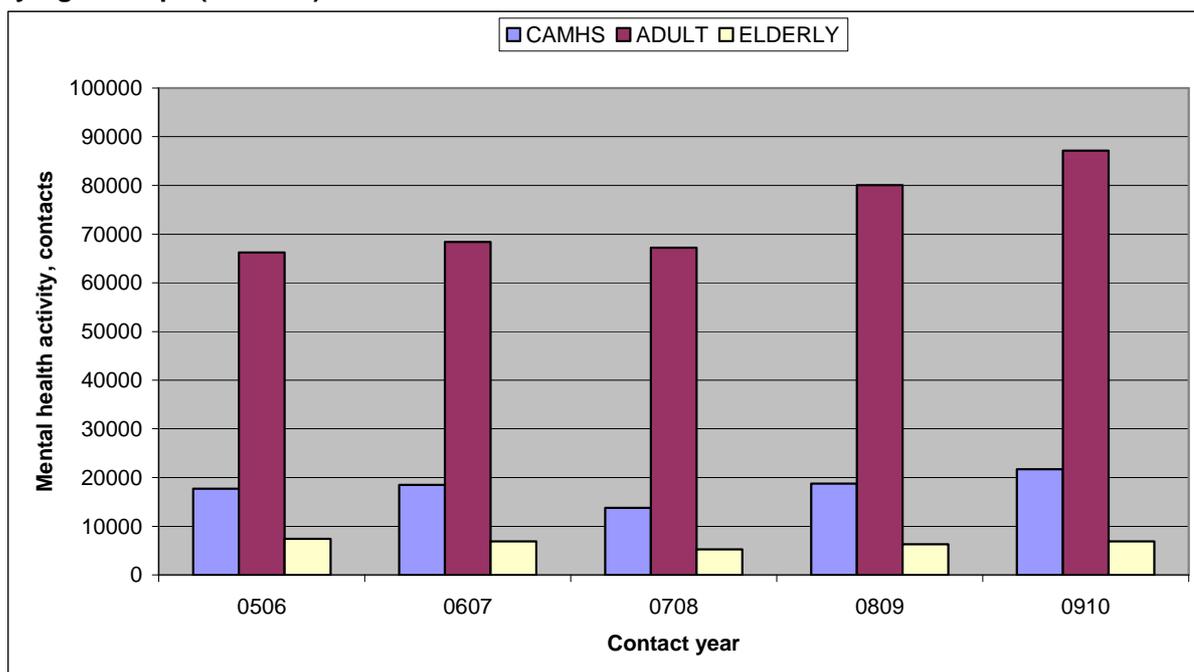
Figure 7: WACHS Community Mental Health Activity by financial year, 2005/06-2009/10, by Aboriginality



Source: MHIS; ATSI = Aboriginal and Torres Straight Islander

The majority of services are provided to adults followed by children and adolescents and the least to older adults.

Figure 8: WACHS Community Mental Health Activity by financial year, 2005/06-2009/10 by Age Groups (Streams)



Source: MHIS

Implications for Services Planning

The increased community mental health activity appears to have had a impact on maintaining the rates and numbers of mental health presentations despite an increasing population. The data in this section points to the need to increase community mental health services to meet the needs of the growing population, the Aboriginal population and the increasing older population.

4.5 Mental Health Mortality

Dementia, suicide and substances (mainly alcohol misuse) are the mental health conditions related to death. In Western Australia, 2008:

- There were 550 deaths classified as mental health related (352 females and 198 males);
- This was 4% of all deaths recorded that year.

Table 11 : Five Leading Causes of mental health related Death for All Persons

Cause	Standardised Death Rate (per 100,000)
Dementia	22.5
Substance use (mostly alcohol)	1.7
Mood disorders (mostly depression)	0.4
Schizophrenia	0.2
Stress related	0.1

Data source: Australian Bureau of Statistics, 3303.0 Causes of Death, Australia, 2008

Table 12: Five Leading Causes of Death for Females

Cause	Standardised Death Rate (per 100,000)
Dementia	23.5
Substance use (mostly alcohol)	0.7
Mood disorders (mostly depression)	0.4
Schizophrenia	0.2
Disorders of psychological development	0.2

Data source: Australian Bureau of Statistics, 3303.0 Causes of Death, Australia, 2008

Table 13: Five Leading Causes of Death for Males

Cause	Standardised Death Rate (per 100,000)
Dementia	20.3
Substance use (mostly alcohol)	2.7
Mood disorders (mostly depression)	0.3
Schizophrenia	0.2
Stress related	0.2

Data source: Australian Bureau of Statistics, 3303.0 Causes of Death, Australia, 2008

Mental health related deaths in WA resulted in the loss of 960 years of potential life (314 female and 650 male).

Table 14: Potential Years of Life Lost

Cause	Years of potential life lost		
	Males	Females	Persons
Substance use (mostly alcohol)	486	54	537
Dementia	123	156	280
Disorders of psychological development	0	99	99
Schizophrenia	33	0	33
Mood disorders (mostly depression)	8	1	8

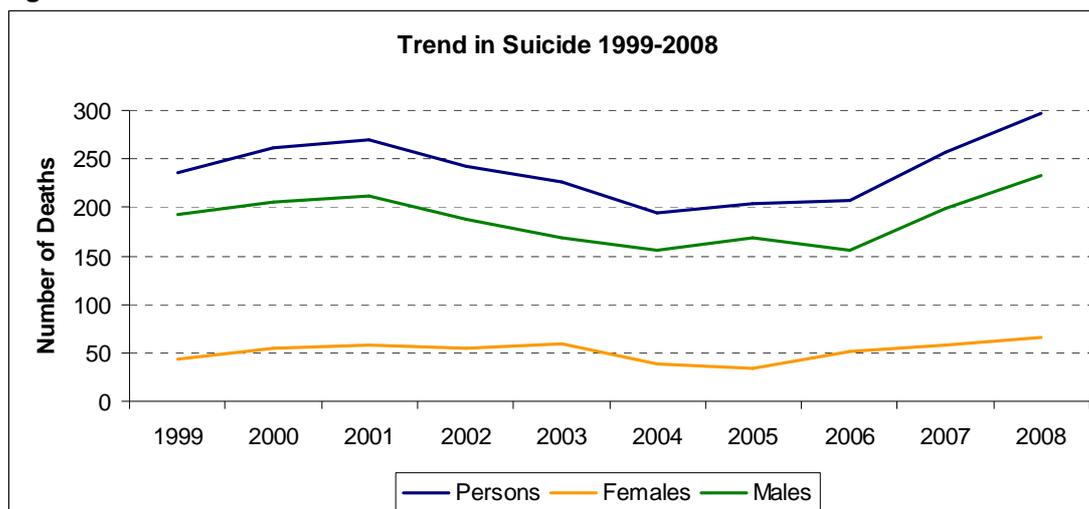
Data source: Australian Bureau of Statistics, 3303.0 Causes of Death, Australia, 2008

Suicide

There were 297 recorded suicides in 2008 (65 females and 232 males). The number had been increasing from 2004 to 2008 at an average rate of 11% (10% for males and 14% for females).

The Western Australian death rate for suicide is 11.2 per 100,000; 14% higher than the Australian rate of 9.8 per 100,000 (2004-2008). The death rate for suicide in males is 17.7 per 100,000 and for females is 4.8 per 100,000 (2004-2008 WA). Intentional self harm is the leading cause of death for the age groups 15-24, 25-34 and 35-44 and it is the fourth leading cause of death in the 45-54 age group.

Figure 11: Trends in Mental Health Suicide 1999-2008



Data source: Australian Bureau of Statistics, 3303.0 Causes of Death, Australia, 2008

In WACHS the suicide rate is higher than the state average with the Kimberley more than twice the state average.

Table 15: Suicides by Health Region (WA) 1997 – 2006 (Age Standardisation x 100,000 persons)

Region	ASR
Kimberley	26.5
Pilbara	12
Midwest	12.7
Goldfields	17.5
Wheatbelt	13.7
South West	11.5
Great Southern	11.9
North Metropolitan	11.2
South Metropolitan	11.9

Source: Epidemiology Branch, Dept of Health, May 2009

Implications for Services Planning

While the trend for suicides had been decreasing over the 6 years to 2004 it has been sharply increasing in recent years with intentional self harm being the highest cause of death in young people.

In WACHS the suicide rate is of particular concern and highlights the need for improved access to early intervention and primary care services as well mental health promotion. There may be socio-economic and environmental factors influencing this trend also.

5 Governance of WACHS Mental Health Services

The MHC is responsible for the policy, planning and purchasing arms of mental health services in Western Australia. Public mental health services are governed by the Area Health Services who report to the Director General of Health.

WACHS operates in a matrix structure in relation to certain service delivery and program areas including mental health. The successful governance and implementation of service reform in mental health requires clarity in relation to the different roles and responsibilities of the Regional Directors, Operations Managers, regional program management and Area and Executive Program Directors.

The WACHS Mental Health Leadership Group comprises the Area Director, Clinical Director (ICAYMHS) and Program Manager; Regional Mental Health Managers and Clinical Directors. This group is responsible for establishing priorities, developing operational strategies, driving mental health reform and linking operational planning to service delivery.

5.1.1 Role of Area Director Mental Health

The WACHS Area Director, Mental Health is responsible for the coordination of mental health services, leads service development and planning and seeks to address system and area wide issues. The Area Director is the initial point of contact for planners and other stakeholders including the Mental Health Commission. This role is supported by the Area Clinical Director ICAYMHS, a program manager and senior program officer.

The role of the Area Director Mental Health is to:

- Lead strategic and operational clinical policy development;
- Monitor and report on key issues to the CEO, DG, the Minister
- Be the primary contact and central point of liaison between WACHS and the Mental Health Commission;
- Support regions to progress mental health reform;
- Work with local managers to facilitate change in the regions;
- Assist regions to manage risks for implementation of reforms;
- Participate and liaise with the WA Health Networks re service models;
- Planning and translation of the Mental Health Health Network service models across WACHS.

The Area Director engages regions initially through the Regional Directors (RDs) and then through regional Mental Health Managers, Clinical Directors and other program leads as directed by the RDs to progress reform in mental health.

5.1.2 Roles of Regions

Regional mental health services have an integrated governance structure with Regional Managers and Clinical Directors (consultant psychiatrists) working in partnership to ensure strong governance. Their roles include:

- Line management of staff and services

- Implementation of mental health reform in WACHS
- Collaboration with the Area Director Mental Health to deliver the reform projects;
- Ensuring regional operations managers and other program managers work collaboratively with the mental health services and the Area Director Mental Health to progress mental health reforms in the regions.

6 Current Scope of Country Mental Health Services

6.1 Current Mental Health Service Delivery Model

A range of mental health services across the continuum of care are delivered in all of the seven WACHS regions from a variety of locations and providers including WACHS, non government providers and GPs. WACHS is the 'provider of last resort' when there are no other providers with the capacity to deliver the range of services.

Services currently provided across country WA include:

- Mental health promotion activities;
- Primary care services through GPs, Aboriginal health services, schools and WACHS emergency departments;
- Community mental health services for all ages though primarily for adults;
- General mental health inpatient care in most country public hospitals;
- Specialist authorised inpatient care in three regional public hospitals;
- Emergency responses for mental health and alcohol and drug issues in all WACHS hospitals;
- Limited mental health rehabilitation services in the South West.

Specialist mental health services in WACHS are primarily delivered through a bio-medical model. A range of general mental health services are also provided by regional and district hospitals, community health and aged care. Management of these services is through population health, nursing and medical directors, aged care and operations managers. All these positions, along with the mental health managers, report to the Regional Director in each of the seven regions.

6.2 Mental Health Promotion

Mental health promotion services in country WA are universally targeted at the general population and selectively targeted at population subgroups or individuals whose risk of developing a mental health problem is significantly higher. These services are provided by WACHS Population Health, WACHS Mental Health as well as other government and non-government agencies.

Mental health promotion activities currently provided by WACHS focus on prevention of mental health problems through building the resilience of individuals and communities to strengthen and maintain positive mental health.

Full time Mental Health Promotion Coordinators are employed in two WACHS regions by WACHS Population Health. The remaining five regions do not have FTE dedicated to mental health promotion but have incorporated mental health promotion into current health promotion staff's role, in some cases dedicating 0.2 of their role to mental health promotion.

Universal Prevention

Universal mental health promotion services are generally provided by WACHS Population Health and include but are not limited to:

- Supporting the Act-Belong-Commit (ABC) campaign – a positive mental health promotion campaign coordinated by Mentally Healthy WA. All WACHS regions, to some extent, support the campaign by implementing a range of local strategies at such as social marketing, building capacity of local organisations to promote the ABC message and supporting sponsorships with the ABC message.
- The South West region supports the 'Understanding and Building Resilience – Suicide Prevention Project in the South West'.
- Provision of education and training, such as the Mental Health First Aid course, to build the capacity of organisations and health professionals to support mental health promotion, is provided to a great or lesser extent in some WACHS regions.
- Activities to promote mental health promotion, particularly during Mental Health Week, are organised by a range of services and agencies, and in some instances in partnership with local government programs. Population health and mental health staff frequently contribute to such activities either by helping with organising the events or as participants.
- Some regions support the implementation of evidenced based mental health promotion school based programs and training for teachers such as the Resourceful Adolescent Program (RAP).

Selective Prevention

Selective or targeted prevention strategies include working with high risk groups such as children of parents with mental illness (COPMI), victims of childhood abuse and neglect, trauma survivors and people with drug and alcohol abuse issues. Many of these services are provided by or in partnership with non-government organisations and availability across country WA is inconsistent and WACHS becomes the default provider.

6.3 Primary Care and Early Intervention

These services vary across regions but primarily fall within the domain of General Practitioner (GP services) and Commonwealth funded initiatives. Services provided by WACHS are limited and include:

- "Headspace" programs: WACHS is involved in consortia in the Kimberley and the Great Southern region servicing Broome and Albany;
- Screening and early interventions for postnatal depression;
- Working in partnership with alcohol and other drug (AOD) services: Services are integrated in the Kimberley and the Pilbara; the Wheatbelt has developed and implemented a Memorandum of Understanding and Shared Care model with the local AOD provider;
- Provision of primary care services through remote nursing posts and accident and emergency which includes suicide risk assessments
- School health services, including health counselling, provided by school health nurses particularly in the secondary school setting.

6.4 Acute Care

Emergency and After Hours Services

After hours services are provided across WACHS by Rural-link, a telephone based service provided by the Mental Health Emergency Response Line (MHERL). This service is staffed by mental health professionals with access to consultant psychiatrists. Callers are referred to Community Mental Health or other services as determined by a telephone assessment.

Emergency care is provided by WACHS regional and district hospitals, nursing posts and remote clinics; general practitioners, police and ambulance services. This is supported in 3 regions by a Consultation Liaison service based at the regional hospital (Bunbury: 0700 - 2300 daily; Albany: 5 days per week and Geraldton: daily during business hours).

Inpatient care

The WACHS currently has three Authorised Mental Health Inpatient Units in Kalgoorlie, Albany and Bunbury. Services are provided for individuals requiring admission and treatment due to an acute episode of mental illness and/or behavioural problems that cannot be managed in a non-psychiatric setting and include:

- Consultation and Liaison;
- Comprehensive assessment ;
- Implementation of treatment;
- Discharge Planning in consultation with carers, referrers and/or Community Mental Health teams

By far the greatest numbers of hospital admissions (separations) for mental health diagnoses in WACHS is to general hospital wards (refer section four inpatient activity). Initial triage and assessment is carried out by hospital staff who refer to mental health services as required. Community mental health services provide in-reach support to these hospitals.

6.5 Community Mental Health Services

Community Mental Health (CMH) services are delivered from 22 separate locations across WACHS (see Appendix 2) ranging from purpose built community clinics to offices and consultation rooms based in district hospitals. The Pilbara and Kimberley Services include community drug service teams. Services are provided:

- By in-reach to local hospitals;
- By outreach to other regional locations on a regular or as needs basis;
- Visiting to patients homes;
- In clinics;
- Other as required.

All regional services are staffed by multi-disciplinary teams including resident and visiting psychiatrists, mental health nurses, occupational therapists, social workers, psychologists and Aboriginal mental health workers. Services provided include:

- Consultation and liaison;
- Referral, triage and assessment;
- Case management and care coordination;
- A range of treatment interventions including psychological counselling, psycho-education, medication management, psychosocial support, carer support and education;
- Rehabilitation in some regions;
- Discharge planning and relapse prevention.

The capacity to access other primary or early intervention services for people suffering from mental illnesses and mental health problems is very limited in most rural and remote locations. This requires that all services develop and sustain positive relationships with those services that are available and also that they are more flexible in the application of access, referral and admission criteria.

Infant, Child, Adolescent and Youth Mental Health Services (ICAYMHS)

The target group for ICAYMHS is children and adolescents 0 to 17 years who:

- Have a diagnosable condition based on ICD-10;
- Experience substantial impairment in functioning due to the mental disorder for the past year on a continuous or intermittent basis, or;
- Have exhibited severe symptoms within the past 30 days coupled with substantial impairment in functioning at the current time.

Referrals to ICAYMHS are received from schools, GPs, youth services, child and school health staff, private and non-government services providers, families and carers. They are prioritised and contacted according to urgency.

Issues

At present there is no capacity to provide infant mental health services. Some areas do not have dedicated youth positions and in other regions there youth counsellors, who treat young people up to the age of 25 years, who are currently being brought into the ICAYMHS network. In one region, there is a very small Youth Mental Health Team (2.0 FTE) which relates primarily to ICAYMHS but also to the Adult Community Mental Health Team.

Whilst ICAYMHS services are available in all regions they are often under considerable pressure due to very limited resources. WACHS has less than 2 Full Time Equivalent (FTE) ICAYMHS consultant psychiatrists and in many locations ICAYMHS staff are isolated and without adequate support and supervision, other than by telephone or video-conferencing assistance. In some areas, they work as lone practitioners accommodated within adult mental health teams. It is expected that adult services will support ICAYMHS when necessary. However this can result in a less than optimal outcome for the consumer.

There are no Early Episode Psychosis programs and few early intervention programs for children and youth. If inpatient treatment is required transfer to the metropolitan area is arranged, resulting in delay in treatment and difficulties for families due to disruption in family life, care for younger siblings, etc. This is particularly difficult for Aboriginal young people because of the separation from their community/culture. A number of initiatives have been implemented to support ICAYMHS staff including the creation of an Acting Clinical Director position, a WACHS ICAYMHS professional support network and a dedicated Training Program in ICAYMHS core clinical competencies.

In many regions facilities require upgrading to become more child and youth friendly and culturally appropriate.

Adult Community Mental Health Services

The current target group for adult community mental health services is adults aged 18 years and over who have moderate to severe mental illness, and/or severe behavioural problems that cannot be managed in a non-psychiatric setting.

Patients are usually referred by their medical practitioner, other government and non-government agencies/services, and self-referral. All referrals are prioritised and responded to according to urgency.

Issues

Whilst adult services are the best resourced mental health services in WACHS this still falls far short of metropolitan levels for the population.

There are no early episode psychosis programs and few early intervention programs for adults and the range of treatment options can vary according to the staff mix of skills and experience. In those regions without mental health inpatient units people requiring inpatient treatment are transferred to the metropolitan or another regional area is arranged resulting in delays receiving treatment.

Older Adult Mental Health Services

The target group for older adult mental health services are adults aged 65 and over (45 and over if Aboriginal or Torres Strait Islander) who are experiencing mental ill-health for the first time or with existing mental health disorders who have developed complications related to old age. Generally those who move into old age with an existing condition will be managed by adult services.

Patients are usually referred by their medical practitioner, other government and non-government agencies/services, and self-referral. All referrals are triaged by adult mental health services, prioritised and responded to according to urgency. If specialist inpatient treatment is required then transfer to the metropolitan area is arranged.

Issues

Only three regions (Great Southern, Wheatbelt and Mid-west) have dedicated resources for the delivery of services to older adults with mental health disorders. WACHS has only one resident psycho-geriatrician who also holds other responsibilities with the service.

6.6 Mental Health Rehabilitation

The target group for specialist mental health rehabilitation services are adults aged 18 and over with complex and chronic mental health issues who need to gain or regain confidence and skills to function effectively in their community.

Non government not-for-profit organisations are the primary providers of non specialist rehabilitation services offering psychosocial support, vocational rehabilitation, supported accommodation, independent living, and inclusion in social and recreational pursuits.

Issues

Dedicated specialist mental health rehabilitation services are only available in country WA in the South West region and are provided by WACHS. This service has been established based upon the principles of recovery.

Strong partnerships are required between government rehabilitation services and non government services in order to ensure good care coordination. NGOs providing these services are not available in all regions, leaving gaps in providing an effective and holistic recovery program to all consumers.

6.7 Telepsychiatry

The use of videoconferencing is an essential component of mental health service delivery in a state the size of WA. The Statewide Clinical and Service Enhancement Program (SCSEP) is coordinated at an Area level and facilitates clinical services, clinical support, management support, training and education initiatives to rural and remote mental health consumers and practitioners via video-conferencing. The program has been designed to enhance access to and not replace mental health services in rural and remote locations.

SCSEP is comprised of a suite of four studios and office located on the ground floor of Fortescue House, Graylands Hospital. It is coordinated by a Senior Program Officer and is supported by the WACHS Telehealth Network Manager and Telehealth Support Officer.

The program is integrated and provides both technical assistance and a wide range of clinical and educational services. The program is user friendly and a help-desk is available for timely assistance. The services delivered by SCSEP include:

- Specialist clinical services in Child and Adolescent Mental Health that are not currently available in the majority of rural and remote locations;
- Training programs in a range of mental health competencies;
- Facilitation of ad-hoc education provided by country, metropolitan and inter-state centres;
- Clinical supervision for mental health professionals in ICAYMHS;
- Regular presentations in the ICAYMHS and Older Adult Psychiatry fields;
- Bi-Monthly videoconference link for WACHS ICAYMHS staff to Princess Margaret Hospital (PMH) Eating Disorders Unit discussing case presentations;
- Facilitation of links between Graylands and rural and remote staff to support discharge planning and family conferences.
- Links across the state with the Mental Health Review Board.

6.8 Collaborations and Linkages

Metropolitan Mental Health Services

Strong links between WACHS, the North and South Metropolitan Area Mental Health Services (NMAMHS and SMAMHS) and the Psychological Medicine Clinical Care Unit (PsMCCU), Women's' and Newborn Health Services (WNHS) and Child and Adolescent Health Service(CAHS) are essential to ensure the best possible care for country residents. Key linkages include:

Coordination:

- The Executive Directors NMAMHS, SMAMHS and WANS with the WACHS Area Director, Mental Health are responsible for coordination of mental health services across the state;
- Assertive Patient Flow and Bed Demand Management.

Inpatient services:

- Referrals from Kimberley, Pilbara, Midwest and Wheatbelt to metropolitan inpatient facilities;
- Child and adolescent referral to Bentley Adolescent Unit and Princess Margaret Hospital;

- Older adult referrals for specialist assessment and treatment.

Statewide services:

A number of statewide services are delivered in the Perth metropolitan area including but not limited to:

- Eating Disorders Team;
- Neurosciences unit;
- Forensic Mental Health Services;
- “Family Pathways” service for children and adolescents;
- Specialised inpatient services.

Private Mental Health services

There are few private specialist mental health services based outside the metropolitan area. Primarily those that are available are funded through Commonwealth initiatives or as Medicare items e.g. Better outcomes/ better access programs; mental health nurse initiative.

Non-government Organisations (NGOs)

Community Supported Residential Units (CSRU)

CSRUs are located in the South West (Bunbury, Busselton), Great Southern (Albany) and Midwest (Geraldton). NGOs are Richmond Fellowship (SW), Fusion Australia (MW) and Albany Halfway House Association (GS). Each of these regional mental health services has a liaison position to support this program.

Drug and alcohol services

Mental health services in all WACHS regions hold memoranda of understanding with state funded drug and alcohol services.

Aboriginal health services

Each region has an Aboriginal Medical Service or other Aboriginal Community Controlled Health Organisations. Mental health services work closely with these organisations.

Commonwealth and state funded initiatives

A range of services across country WA including independent living support, personal helpers and mentors, social support are based throughout the regions.

7 Current service and infrastructure developments

Service developments

Aboriginal mental health

Under the Closing the Gap National Partnership Agreement, the State government committed a total of \$22.47million over four years towards the establishment of a Statewide Specialist Aboriginal Mental Health Service. WACHS is in the final stages of negotiating with the Mental Health Commission the distribution of funding allocated to delivering services in Rural and Remote WA.

Perinatal depression

Funding has been allocated by state and federal governments for services relating to perinatal depression to develop specialised regional positions.

To identify the most effective allocation of funds the State peri-natal Mental health unit and WACHS undertook The Perinatal Depression Project to map services and activities related to perinatal depression in the seven WACHS regions. The project report and recommendations are being finalised.

Older adult Mental Health

The WACHS is in the process of implementing a three year mental health program for older adults via the COAG sub-acute care initiative. This and other services to older adults are carried out in collaboration with WACHS Aged Care services.

There is now a visiting psycho-geriatric specialist schedule in place for each of the regions with a dedicated link to a metropolitan older adult mental health service. Additionally several positions have been created/funded to provide older adult mental health clinicians attached to mental health teams in the South West, Wheatbelt and Goldfields (total of 4.4 FTE).

Integrating mental health and drug and alcohol services

In 2008/09 the WACHS Wheatbelt Mental Health Service (WMHS) was funded through the State Mental Health Strategy:

“To develop an integrated model of service delivery between the WMHS and the Wheatbelt Community Drug Service Team (WCDST) in accordance with evidence based best practice and a ‘no wrong door’ service response philosophy. Those clients experiencing co-occurring substance misuse and mental health issues will be perceived as being the ‘core business’ of both services in acknowledgement of the high prevalence of clients with co-occurring substance misuse and mental illness.

The service aims to build the capacity of WMHS and WCDST services to provide effective referral pathways; screening; assessment; case management / treatment; continuity of care and effective discharge plans, if appropriate, in order to achieve better outcomes for this client group.¹²

2 Wheatbelt Mental Health Service & Wheatbelt Community Drug Service Team Integrated Service Model Manual June2009

This model will form the basis for further development in integrating mental health and alcohol and other drug services across WACHS.

Nurse Practitioners

Development of the Nurse Practitioner role in rural and remote mental health is currently underway. This will provide capacity to extend services in remote areas, support junior nurses and develop services that are currently limited or unmet. Strategies to create positions, including access to new funding, are required.

Infrastructure developments

There is a range of hospital and health infrastructure developments currently occurring or in the planning stages across WACHS (refer Appendix 2) which will improve mental health service delivery including:

- A new 14 bed adult mental health inpatient unit at Broome which serves the Kimberley and Pilbara population and will have a strong focus on Aboriginal Mental health;
- A new 16 bed unit at Albany as part of the new Albany hospital;
- Planning will shortly commence for a new unit at the Geraldton health campus;
- Planning for upgrading of community mental health services and facilities in Busselton, Wheatbelt and Esperance is underway;
- Upgrading of or new emergency departments is underway or being planned for South Hedland, Kalgoorlie, Esperance, Kununurra, Albany, Bunbury, Geraldton, Carnarvon, Busselton, Merredin, Narrogin, Karratha and other smaller hospitals in the Pilbara, Goldfields and South West. This will include consideration of assessment and quiet areas for mental health patients and their families.

8 Key principles guiding service planning and delivery

The following key principles are proposed as a sound basis for mental health service planning and development in WACHS:

Accessibility and engagement: *Services should be accessible to all people who need them, across cultures, language groups, communities of place and interest, abilities and socioeconomic groups. Similarly, mental health services should actively engage relevant groups of people within the community.*

Consumer and carer involvement: *The involvement of consumers of all ages and their families and carers should occur in all aspects of service policy, planning, delivery and evaluation.*

A preventative approach with a recovery focus: *Expertise should be developed in these areas using a sound evidence base, to provide new opportunities for preventing mental illness and/or minimising or containing its effects in the short term and throughout adult life.*

Continuity of care: *A continuum of service provision should occur across the service system, through developmental and age transitions and through stages of care.*

Workforce and workforce performance: *A suitable range of workers needs to be available, with an appropriate range of professional expertise, an understanding of the issues facing the populations they work with, and the ability to exchange skills and expertise across a team.*

Quality and performance: *The provision of care of assured quality is required of all health services.*³

The Recovery Principle

The principle of recovery is considered by WACHS as fundamental to service delivery models across the continuum of care. It features prominently in international, national and state literature relating to the development of mental health services into the future. Recovery is described as:

*“... a set of values about a person’s right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of ‘hope’ in sustaining motivation and supporting expectations of an individually fulfilled life”*⁴

³ Adapted from: *Responding to the Mental Health Needs of Young People in Australia: Discussion Paper: Principles and Strategies. Mental Health Strategy, 2004.*

⁴ Shepherd, G., Boardman, J., & Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Mental Health Act Principles

The Western Australian Mental Health Act (1996) states that:

“The objects of this Act include —

- (a) to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity;*
- (b) to ensure the proper protection of patients as well as the public; and*
- (c) to minimize the adverse effects of mental illness on family life.”*

Whilst the relevance of the Act is primarily to guide mental health staff in their work with consumers these principles should be considered in the development of mental health services and facilities in WACHS.

A review of the Act is currently underway and it is hoped that improved options such as videoconferencing for assessment of persons referred under the Act will be included.

9 WACHS Mental Health Priorities: meeting identified need.

The WA Mental Health Commission proposes a vision for a mentally healthy WA that has a strong emphasis on promoting social and emotional well being, encouraging early intervention for emerging mental illness and supporting recovery from mental illness. This is a population based approach supported by readily available and easily accessible specialist mental health services.

The Mental Health Commission's 2010 consultation paper identified actions and initiatives for nine key reform areas and six specific population groups. Appendix C of that paper aligns the actions with the *Fourth National Mental Health Plan, 2009 - 2014*.

WACHS supports these actions and initiatives along with the identified key priority areas for WACHS mental health services to meet identified needs for the WACHS population.

There are four priorities that WACHS considers essential to enhance mental health services in regional WA across the entire continuum of care and other key future service models and priorities for each element of the continuum of care.

To address these priorities WACHS needs to develop a comprehensive mental health services plan for the Area and for each region across the continuum of care in collaboration with our health partners and with the Mental Health Commission.

9.1 Priorities to Strengthen Services across the whole Continuum of Mental Health Care

9.1.1 Workforce

The building of a sustainable well supported and appropriately skilled mental health workforce is the highest strategic priority to secure the future of mental health services in WACHS. At the time of writing there is no state-wide coordination of mental health workforce planning and development.

Specific workforce gaps identified in country WA are:

- child and adolescent specialists;
- consultant psychiatrists;
- allied health professionals
- Indigenous mental health workers.

In addition to specialist workforce the expectation is that all clinical staff in general medical areas, paediatrics, community health and aged care are trained to be able to identify and respond to mental health presentations.

Workforce Benchmarks

The World Health Organisation suggests that 1 psychiatrist per 10,000 is acceptable. In Australia there are 1.4 psychiatrists per 10,000 including private psychiatrists. There are very few private psychiatrists in regional Western Australia, placing an increased burden on public mental health services to provide these services.

If the WHO benchmark were applied to country WA there would be over 50 psychiatrists for its population. In 2009/2010 WACHS employed approximately 11.5 FTE consultant psychiatrists or 0.2FTE per 10,000. This falls far short of the WHO recommendation. Further literature review and analysis is warranted in this area as agreed benchmarks for other mental health professionals are not readily available.

The total mental health FTE per population for WACHS is around 70% that of the state, i.e. 4.4 compared to 6.2 (table 1). It is proposed that as a first target parity with metropolitan services plus an additional allowance to allow for vast distances be set as an initial target for WACHS.

Table 16: Total FTE per 10,000 population in WA

2011	N Metro	S Metro	WACHS	Total
Total FTE per 10,000 population	5.7	6.6	4.4	6.2
Total FTE per 10,000 population (inc WNB & CAHS allocated to NM & SM)	6.3	7.2	4.4	6.2
CAHS using 0-17 pop				1.5
OAP using 65+ pop				4.4

Source: Average FTE for Ambulatory Services 2008/09, Mental Health Commission and Series B population projection, ABS

Leadership and management within mental health should be recognised as requiring a distinct set of skills and appropriate support and development offered to ensure contemporary practices in mental health service management.

Attraction and Retention

High levels of staff turnover impact greatly on services' sustainability and at times services have been reduced due to inability to recruit. Consumers expect and should be able to access mental health services with a reasonable expectation of continuity of case manager and of planned handover to another staff member when there is a change.

Professional isolation and the expectation to provide a broad scope of services with an emphasis on acute and crisis intervention often act as a deterrent to interested professionals along with the higher cost of living in rural areas and reduced access to public and community services.

- Specific measures to attract people to rural and remote areas include:
- Access to reasonable housing, education opportunities, social and recreational activities;

- Proper remuneration for the increased cost of living outside the metropolitan area for the whole rural sector. This could be scaled according to regional differences but must be considered for all regions;
- Costs (financial and social) of relocation;
- Access to professional support, development and mentoring (professional isolation);
- Maintenance of adequate staffing levels to prevent burnout and attrition;
- Clear processes and strategies to manage staff shortages when unavoidable;
- Payment of retention bonuses linked to length of service.

Continuing Professional development

Mental health services are by nature staff intensive. Access to continuing support and professional development are critical to ensure sustainable services and to attract and retain staff. WACHS mental health staff should also be sufficiently resourced to provide support and supervision to other WACHS and external health staff on mental health issues.

Clinical supervision is considered essential in mental health however it is difficult to provide to isolated staff. Strong links across all state mental health services is required to support access to clinical supervision for all mental health staff within WACHS.

The National Practice Standards outline an extensive suite of competencies for mental health professionals in the following areas:

- Rights, Responsibility, Safety and Privacy
- Consumer and Carer Participation
- Awareness of Diversity
- Mental Health Problems & Mental Disorders
- Promotion and Prevention
- Early Detection and Intervention
- Assessment, Treatment, Relapse Prevention and Support
- Integration and Partnership
- Service Planning, Development and Management
- Documentation and Information Systems
- Evaluation and Research
- Ethical Practice and Professional Responsibilities

Workforce Planning Priorities

WACHS needs to take a proactive approach to mental health workforce planning and development to support the delivery of future service models and demand for services.

Workforce Benchmarks

- Further research and consultation to establish FTE benchmarks. This should take into account measures of case complexity and recognition of distance and geography;
- Setting of benchmark targets where appropriate taking into consideration workforce shortages and alternative workforce models (see below);

Development of innovative attraction and retention strategies.

Capacity to offer substantial incentives for mental health professionals to work in country areas must be developed.

Workforce structure and models

- Further research and consultation to identify innovative and alternative workforce models.
- Development of an enhanced workforce structure to support a greater range of skill backgrounds (e.g. Certificate IV TAFE trained staff) and build workforce capacity.
- Future workforce models should include an increase in appropriately trained Aboriginal people working within WACHS services.
- Strategies to create Mental Health Nurse Practitioner positions across WACHS.

Supervision and support

There is a need to strengthen and develop:

- Support for training in clinical supervision will provide depth within WACHS to support new staff. The SCSEP program is pivotal in supporting this.
- Comprehensive orientation, including state and area facilities and programs;
- Training and education programs;
- Staff attendance at state-wide training and other centrally based learning opportunities;
- Stronger links with colleagues in metropolitan services to broaden access to clinical supervision;
- A sustainable training strategy to support mandated data collection and record keeping
- Training in prevention and promotion.
- Establishment of a mental health learning and development coordinator.

9.1.2 Aboriginal Mental Health

The WACHS Mental Health Program considers an integrated service delivery model to be the most effective means of delivering specialist Aboriginal mental health services to regional Western Australia. It supports and promotes partnerships with other services and agencies such as the State-wide Aboriginal Mental Health Service (SAMHS), Aboriginal Medical Services (AMS), Population Health Services, and Aboriginal Community Controlled Organisations (ACCHO). The connections of Aboriginal people to country should dictate that every effort is made to offer interventions locally. This will require the integration of mainstream mental health services with Aboriginal mental health specialists, cultural consultants and traditional healers. Non-Aboriginal mental health workers will need to undertake training in working with Aboriginal people.

To improve outcomes for Aboriginal people seeking help for mental health disorders a culturally appropriate and sustainable community service delivery model, built upon the principles of social and emotional wellbeing, is required.

The WACHS Mental health leadership group has developed a discussion paper outlining more detail on this priority and work has commenced on planning for this service.

9.1.3 Telepsychiatry

Telepsychiatry presents an efficient and effective means of enhancing provision of services to rural and remote locations. Technical improvements and increased availability of the broadband services across WA will support opportunities for further development of this highly innovative and award winning service.

Telepsychiatry ultimately needs to be fully integrated with and a routine part of Mental Health activity. Strategies to support this need to include:

- A comprehensive plan for the continued support and development of SCSEP;
- Access for all staff to on-line learning and videoconferencing facilities;
- Develop purpose-built facilities that will increase the number of studios available for use in Perth and in regional centres;
- Ensure end points are available in remote areas as they receive access to required infrastructure;
- Providing desktop videoconferencing capacity to key clinical and managerial positions;
- Providing adequate technical and administrative support to SCSEP staff;
- Train clinical staff in the use of videoconferencing for service delivery and other functions.

9.1.4 Dual Diagnosis

Up to **85%** of people with mental health problems also exhibit a co-morbidity of substance use disorder. This warrants a single service provider approach for people with dual diagnoses.

Mental health and drug and alcohol services across WACHS need to build on the Wheatbelt model of 'no wrong door' approach and improve cooperation and collaboration or where possible become integrated services. Options to achieve this include:

- Amalgamation of funding sources to develop fully integrated services;
- Co-location of services;
- Shared care models including joint case conferencing and care planning;
- A workforce skilled in both MH and DAO interventions.

The WACHS already has co-located services in two regions. Where possible this should be extended to include all regions.

WACHS will support the development of alternative service models to provide integration of mental health and drug and alcohol services that will offer a range of interventions including detoxification services, facilities and rehabilitation.

9.2 Priorities for each element of the Continuum of Care

This section proposes broad service models, priorities and strategies to guide further planning and development of country mental health services, including non-specialist services, at each stage of the continuum of care. Underpinning this framework is the

premise that people experiencing emotional distress, behavioural disturbance and/or psychiatric symptoms can and will present to any facility in WACHS. Staff working at these facilities require the skills to provide an appropriate, timely response utilising available resources and within a safe and user friendly environment.

There are significant gaps in the mental health care continuum in rural and remote regions. The greatest of these are in primary care, prevention, early intervention and rehabilitation i.e. non acute services. Non government organisations are often funded to provide these services however when they are not sustainable or available service provision defaults to public health services to avoid service gaps.

9.2.1 Mental Health Promotion

'Mental Health Promotion' has been defined as *'any action taken to maximise mental health and well-being among populations and individuals that focuses on improving social, physical and economic environments that affect mental health and enhancing the coping capacity of communities as well as individuals'*⁵. Every contact with a health service is an opportunity to support mental health promotion.

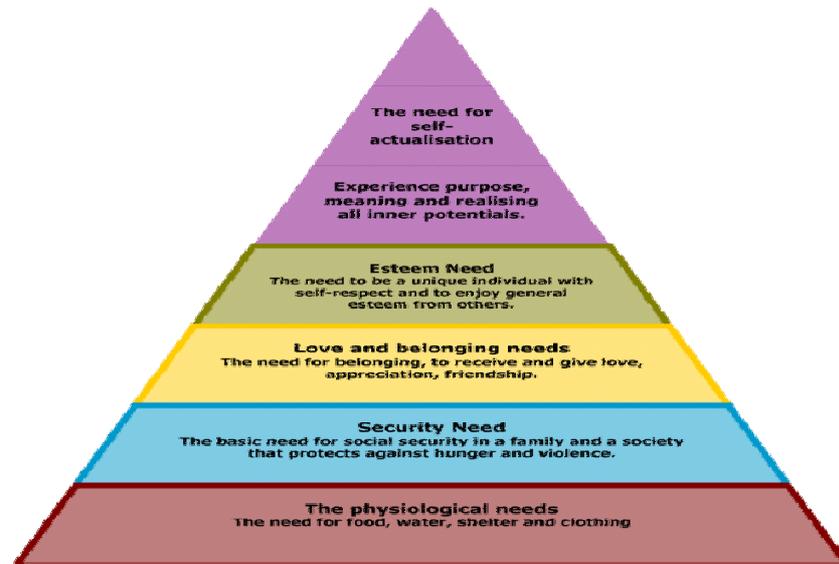
Current evidence indicates an approach to mental health that incorporates mental health promotion can significantly impact on the burden of mental health problems and mental health disorders in the community.

The social determinants of health (clean water, healthy food, adequate housing, safety, access to health services), also reflected in Maslow's⁶ hierarchy of needs are critical in the attainment of social and emotional well being. So fundamental are these needs that mental health promotion interventions which do not address these issues will fail, which is evident in the high needs of Aboriginal communities.

In addition to addressing the risk and protective factors that influence mental health, the 'coping capacity of communities as well as individuals' is an important part of mental health promotion.

⁵ Organisation WH. Prevention of Mental Disorders: Effective interventions and policy options. A report of the WHO and the Prevention Research Centre, Universities of Nijmegen and Maastricht. Geneva World Health Organisation; 2004.

⁶ Maslow, Abraham. *The Theory of Motivation*. Originally Published in *Psychological Review*, 50, 370-396. 1943



Key Priorities and Strategies for future Mental Health Promotion Services

The key priority for WACHS is to recognise the key role it has to play in supporting the work of government and non-government organisations in addressing these basic needs through advocacy for the communities it works with. With additional resources strategies to address this priority could include:

- Supporting community networks and social inclusion;
- Engaging with Aboriginal and CALD communities to ensure culturally appropriate opportunities for inclusion;
- Facilitating the provision of appropriate and contemporary information to media, other agencies and community groups;
- Building capacity within WACHS to ensure that every point of entry into the health service is able to support mental health and well being in the community;
- Working with local government and health services to identify gaps in service delivery and assist in advocating on behalf of the community for those services to become available.

9.2.2 Primary Care, Prevention and Early Intervention

Specialist mental health services can only function efficiently where there is comprehensive primary care provision. This is an area which requires significant attention and investment in regional Western Australia.

Traditionally specialist WACHS mental health services have access criteria that utilise a prioritisation framework based on available resources and focus on risk and need determined by severity of symptoms, level of behavioural disturbance and acuity. Treatment is offered via a largely bio-medical model. Population health services in WACHS and through non government providers are not adequately resourced to support early intervention for emerging mental health issues and there are rarely appropriate staff such as social workers based in rural hospitals to support people presenting in distress and /or crisis.

The primary care sector is supported by COAG and Medicare initiatives that have proven difficult to implement and sustain in many rural and remote regions. GPs are the main providers and there are very few GPs in the country outside of the Southern regions. GPs again often utilise a bio-medical approach, there are frequently long waiting times and often payment is required at the time of the appointment with bulk billing unavailable.

Supporting a system that is not able to act until a person is so disabled by psychological distress or psychiatric symptoms that their ability to engage with services and participate in treatment decisions is compromised is ethically questionable.

Services such as counselling and support for vulnerable people when significant events occur that might trigger a spiral into mental ill-health are very limited in regional Western Australia. Where they are not present at all or unlikely to be present WACHS is the default provider.

Key Priorities and Strategies for all Primary Care, Prevention and Early Intervention Services

The key priority for primary care, prevention and early intervention (PPEI) services is to review and broaden community mental health service delivery models from a primarily bio-medical model to a bio-psycho-social model. This needs to include review of access criteria and take into consideration regional differences and available workforce and service providers.

Strategies across all ages to support this priority are:

- Identification and replication of successful early intervention programs;
- Commonwealth /state partnerships to employ appropriately trained staff to work in counselling roles in a range of health and primary care settings.

Facilities

- Development of facilities should consider:
- Opportunities for co-location within health, general practice and with other government services and NGOs.
- Age friendly buildings.

PPEI Services for infants, children and young people

There are extremely limited services for this age group in rural WA. As the providers of child, maternal health and school aged services, population health services have a key role to play in primary care, prevention and early intervention for mental health issues along with GPs, other government (particularly education and child protection) and non government organisations.

Key priorities and strategies for PPEI services for children and young people.

The key priorities for this age group are:

- A) To invest in positions such as developmental psychologists and other allied health professionals who specialise in psycho-social interventions in a community health settings; and
- B) To have stronger links with ICAYMHS to support early identification by consultation and liaison, joint assessments, shared care and clear referral and care pathways. Key targets would include:
 - Attachment disorders;
 - Children of parents with mental illness;
 - Foetal alcohol spectrum disorder;
 - Aboriginal and other children at risk due to their circumstances;
 - Children in care;
 - Co-occurring drug and alcohol issues
 - Young offenders.

Key strategies to enable this priority to be addressed include:

- Working in a more integrated manner across this sector.
- Advocating for “Headspace” programs, or similar for all regions and developing capacity to link them to smaller communities;
- Strengthening of specialised ICAYMHS to enable early intervention (either directly or through consultation and liaison with other providers) for those at high risk of developing persistent problems;
- Development of Infant, child and youth community networks.

PPEI services for adults

Adults with emerging mental health issues present in many different settings including GP surgeries, hospital and other emergency services, workplace employee support programs and contact with telephone help lines. Frequently the opportunity for early assessment and intervention from specialist services is lost due to pressure on those services to respond to acute and high risk emergency presentations.

Key priorities and strategies for PPEI services for adults and older adults.

The key priority to strengthen PPEI services for adults and older adults is to have readily available and accessible counselling, support services and early psychosis programs.

Key strategies to enable this priority to be addressed include:

- Education and training of all health staff, particularly emergency staff, to confidently and competently respond to presentations of people experiencing psychological distress and /or behavioural disturbance;
- Increasing capacity of mental health services to provide consultation, liaison and support to other health staff and other agencies and service providers, ensuring that appropriate assessment and referral takes place;
- Review of existing regional specialist mental health service models including access and admission criteria, to provide early identification and intervention strategies where no other service provider exists.

Strategies for older adults should include:

- Improved capacity to provide carer support and information;
- Formalised training for mental health, community health and aged care staff and GPs about older adult mental health and screening for disorders.

Facilities

See community mental health

9.2.3 Acute Care

Emergency services

Emergency department liaison offers an important opportunity for identification of problems and appropriate referrals. However, the numbers of mental health presentations to emergency departments suggests that dedicated emergency department liaison positions working from hospitals might not be an efficient model in all hospitals and the use of other models needs to be considered.

Key priorities and strategies for emergency mental health services

The key priority is to review of mental health emergency presentations and service needs in EDs and the community with recommendations for a range of models to appropriately address the demand.

Key strategies to enable this priority to be addressed include:

- Comprehensive and sustained training and support for ED personnel in providing an appropriate level of assessment and short term interventions, managing suicidal behaviour and responding to aggression;
- Ready access to sufficient personnel in ED departments to support an appropriate response to people who are highly agitated and aggressive;
- Clear, appropriate processes and referral pathways to meet emergency presentations of Aboriginal people, older adults and young people.

Facilities

All WACHS emergency departments should have a comfortable, low stimulus area to support sensitive and thorough assessment and consultation.

Inpatient care

Inpatient care closer to home is a key principle as long as the inpatient care is supported by appropriately resourced community mental health services. Over the next ten years the WACHS supports the current strategy of Pilbara residents accessing inpatient care in Broome and Perth and the Wheatbelt residents accessing inpatient care in Perth. This will need review as the population increases.

Key priorities and strategies for inpatient mental health services

The key priority is to review and reform of inpatient models of care consistent with the principles of recovery.

Key strategies to enable this priority to be addressed include:

- Development of specialist inpatient services must include multidisciplinary teams to provide comprehensive medical assessment and care, a therapeutic program and capacity to provide 24/7 consultation, advice and support including where required on-call services;
- Implementation of the use of advance directives to ensure integrated care across the continuum.

Facilities

- Planning to inform the development of authorised facilities in Geraldton;
- Consideration of needs for young people and older adults in development of facilities to support locally based care where possible.

Alternatives to inpatient acute care

To support early intervention, early discharge and care provided locally and with the least restriction, alternative 'inpatient' strategies should be considered where possible. It should also be noted that at times admission to hospitals could be prevented if those presenting were able to access crisis accommodation.

Priorities for consideration include:

- Step down/up facilities; effectively level four care as delineated in the state-wide WA Health Clinical Services Framework (S 3.2 p 10). This might be offered in district hospitals or in separate facilities in regional and district centres depending upon need and capacity.
- Training to support these services including response to presentations and care planning;
- Rapid response/assertive community intervention options in major centres to support acutely unwell people in their homes where appropriate.
- Crisis accommodation with next day follow up by community services.

9.2.4 Community Mental Health Services

The efficient provision of primary and inpatient mental health care is dependent upon the availability of comprehensive mental health care in the community. The data and national and state mental health plans indicate that community mental health services need to be a high priority for service and facilities planning. This includes specialist WACHS community mental health services, and services provided by non government, Aboriginal Medical Services, private providers and GPs.

This section focuses on the specialist community mental health services provided by WACHS.

WACHS needs to review and develop its community models of mental health care in line with the principles described in section 8 that will meet the needs of Aboriginal people, young people and their families, older adults and those with dual diagnosis. This requires a greater flexibility than is currently achievable within existing resources.

Careful planning is required to develop the most appropriate location and facilities from which to provide services to young adults, families/carers seeking support and information and those recovering from mental illness. A small percentage of people experiencing mental illness can at times exhibit aggressive and threatening behaviour (as indeed can occur in any public building). Staff and patient safety is a priority but facilities need to be carefully designed to maximise a safe as well as therapeutic and culturally appropriate environment for early intervention, treatment and recovery.

Key priorities and strategies for all community mental health services

The key priority is to review and reform regional service delivery models of community mental health care, including:

- Ensuring consistency with the principles of recovery;
- Access and admission criteria;
- Supporting early intervention and dual diagnosis;
- Taking into account regional differences and workforce availability.

Key strategies to enable this priority to be addressed include:

- Establishment of local networks to support strong interagency collaboration supported by administrative staff;
- Shared care plans for complex presentations;
- Capacity to facilitate monitoring and treatment of general health and physical co-morbidities;
- Creation of opportunities for staff to attend training and development opportunities on a regular basis to support more flexible and responsive approaches.
- Co-location of some mental health staff with other services particularly general practice, community health, Aboriginal health organisations and drug and alcohol services;
- Consideration of two “levels” of mental health service facilities; one being located near to acute psychiatric units and the other being located in readily accessible areas in the community with a focus on providing a more therapeutic environment.
- Consistent processes and strategies for identifying and responding to high risk situations, including rostering of adequate staff and regular and sustained training for all staff.

Facilities

Facilities design should support an appropriate balance between staff safety and a therapeutic environment.

Infant, Child and Youth [Community] Mental Health Services

In 2007 the Director General of Health commissioned Professor Barry Nurcombe to undertake a review of Child and Adolescent Mental Health Services in Western Australia. Several of the recommendations from this report are critical priorities for future WACHS ICAYMHS and include:

- The need to adequately fund CAMHS services (to approximately 20% of total mental health budget) so that CAMHS can be enhanced to become an ICAYMHS service;
- The need to improve emergency services;

- The need to increase numbers of child and adolescent psychiatrists (SCSEP was identified as being pivotal to achieving this for WACHS);
- The need to consider co-location of CAMHS services with other relevant services;
- The need for improved consultation with Juvenile Justice;
- The need to establish services in the area of infant mental health;
- The need to create joint initiatives with the Commonwealth government.

A significant investment in evidence based mental health services for infants, children, adolescents, youth and families in WACHS regions is required in order to:

- Increase access to appropriate services locally;
- Provide timely interventions;
- Reduce pressure on metropolitan services;
- Reduce pressure on families needing to travel to receive services;
- Reduce the suicide rate;
- Reduce the incidence of preventable mental health disorders in the adult population;
- Reduce the incidence of substance abuse;
- Improve school attendance; and
- Reduce conduct disorder and subsequent entry to the criminal justice system.

Key priorities and strategies for ICAYMHS

The key priority for ICAYMHS is to develop a comprehensive service and workforce plan for ICAYHMS across WACHS which will sit under the whole of WACHS mental health services plan.

Key strategies to consider within the plan include:

- Upgrading the ICAYMHS Clinical Director position to full-time with confirmed funding to allow for a permanent appointment;
- Increasing numbers of ICAYMHS staff providing services;
- Improving training and support to staff working in ICAYMHS;
- Improving capacity of adult mental health, general health and other services to identify, respond to and refer children, adolescents and families presenting in distress;
- Developing appropriate local options for inpatient care and respite when needed;
- Provide prevention and early intervention services;
- Consideration of an integrated model of care to reduce staff isolation and increase accessibility of services.

Other key strategies include:

- Improved collaboration with the Departments for Child Protection regarding the mental health needs of children and adolescents in care
- Improved collaboration with both Disability Services Commission and the Education Department.

Adult Community Mental Health Services

As the population increases and ages so will the need for adult community mental health services. In addition to the general priority strategies for all community mental health services the following is a priority for adult services.

The key priority for Adult Community Mental Health Services is to review and reform the service delivery models to re-direct focus from acute community care and crisis responses towards recovery oriented community services that take into account dual diagnosis and early intervention. This will require a range of workforce development strategies.

Older adult Community Mental Health Services

The population data suggests that this will be the highest area of increased demand over the next 10 years. The key objective in the future is to improve care for older adults with mental health conditions.

Key priorities and Strategies for Older Adult Community Mental Health Services

The key priority is to develop a comprehensive older adult mental health service plan which, like the ICAYMHS plan, will sit under the overall WACHS mental health service plan.

The key strategies to consider in the older adult service plan include:

- Partnerships between aged care and mental health services including improved joint assessment and care planning
- Improved access to specialist consultants and liaison services to support both aged care and mental health services in meeting the needs of this group.
- Review of criteria for referral/transition to older adult services to ensure the needs of Aboriginal people and those with early onset disorders are met;
- Training of mental health, general health and aged care staff in managing older adult mental health and general health conditions.
- Improved understanding of the needs of older Aboriginal adults (45+).

Facilities

- Development of age friendly facilities;
- Inclusion of older adult inpatient services in future infrastructure developments.

Another key priority is to review the “sub-acute” aged care program and expansion into all regions with aged care services.

9.2.5 Rehabilitation

There has been a trend away from public mental health services providing rehabilitation services. In regions where there are strong non-government organisations with established experience in delivering mental health services this is a welcome enhancement for consumers. However, where this is not the case it has resulted in gaps or uncoordinated services.

Key priorities and strategies for Mental Health Rehabilitation Services

The key priority is to develop a service delivery model that promotes strong partnerships between mental health services, NGOs and community services to deliver mental health rehabilitation services. This model will need to take into account regional differences and workforce/service provider availability.

Key strategies to address this priority include:

- Advocating for increased residential, community supported living and independent living services; recreational, vocational, educational and social opportunities;
- Development of networks of care between mental health services and NGOs to support comprehensive and coordinated rehabilitation services;
- Identification and replication of successful programs;
- Commonwealth/state partnerships to ensure sustainability of rehabilitation services.

Facilities

- Co-location of services.
- Access to facilities that support the development of independent living skills, either through local resources or the mental health service.
- Therapeutic facilities that foster return to or attaining of independent living are required. These could be developed in partnership with NGO's.

10 Building the evidence base

This paper represents an important step from WACHS towards building an evidence base from which to plan mental health services into the future. The compilation of existing data from across regions and the continuum of care into a single document has not been undertaken previously. This information requires further development to create a profile for each region and to fill gaps in data that have been identified. This section describes existing data collection and reporting and attempts to identify key areas for further development.

10.1 Monitoring and reporting

To support the ongoing monitoring, evaluation and planning of mental health services basic information needs to be collected e.g. number of patients seen, number of contacts, and number of occasions of service. At specific times outcome measures are collected to inform acuity of presentations and outcome of interventions. Successful capture of all information is dependent upon input by clinical staff and requires ongoing training to ensure accurate data.

All Mental Health Services across WACHS are required to enter patient data into the PSOLIS (Psychiatric services online information system) database. The National Outcomes and Casemix Collection (NOCC) data collection commenced in all jurisdictions in Australia in 2004 and clinician participation in collection and entry of NOCC outcome measures into PSOLIS is a mandatory requirement for all public mental health services. Outcome measures can help identify areas where significant problems exist and guide clinical care. NOCC data can be used at different levels within the organisation:

- Service level;
- Program level;
- Individual client level;
- Individual clinician level.

The PSOLIS Ad Hoc Reporting (PAHR), is available to generate reports; its development is ongoing. PAHR will enable Regional Mental Health Services to access their own data and build reports. WACHS currently has one license for this reporting tool and is developing strategies to make the use of this system more widely available. This will be critical in light of the new Activity Based Funding (ABF) within the whole of health and the Mental Health Commissions' Purchaser/Provider model of funding mental health services.

WACHS will be required to demonstrate that its mental health services provide value for money and are effective. There are an increasing number of WACHS mental health services funded by COAG. These services have specific deliverables and KPIs which need to be reported to the Australian government. Key strategies to facilitate future monitoring and reporting include:

- Implementation of a sustainable training program for staff in the use of PSOLIS and collecting outcomes measures to ensure integrity of data;
- Purchase of more licenses and investment in training, ongoing development and supportive infrastructure;
- Enhancements to PSOLIS and an investment in the development of PAHR across WACHS to ensure more accurate reporting against deliverables and KPIs.

10.2 Links to Centre for Country Health Research

A key action for the WACHS is to establish the WA Centre for Country Health Research and Education: an inter-disciplinary health service research and education program. The WA Centre for Country Health Service Research and Education will provide professional development and further education and research opportunities for staff and to benefit regional communities.

Mental Health is a high priority both nationally and at State level. The development of evidence based mental health services in WACHS is dependent upon information that is relevant at a local level and will be supported by this WACHS priority.

11 In Conclusion

Mental health is experiencing an unprecedented high level of public exposure. Additionally the current political climate has put regional Australia and Western Australia high on the agenda for government. Mental Health care and services in regional WA have generally developed in ad-hoc rather than planned ways. It is imperative that WACHS develops these strategic intentions into clear service and workforce plans for the next three, five and ten years in line with national and state strategic directions and intentions and in collaboration with the WA Mental Health Commission. This will ensure that future mental health services meet the needs and demands of the growing country population across the continuum and spectrum of care.

Appendix 1: Regional Mental Health Service Locations

Kimberley Mental Health and Drug Service (KMHDS)

<p><i>Broome</i> Cnr Anne and Robinson Streets, Broome WA 6275 Tel: 08 9194 2640</p>	<ul style="list-style-type: none"> • Broome and surrounds • Dampier Peninsula communities • Bidyadanga • Other communities as required
<p><i>Derby</i> Cnr Clarendon and Neville Streets, Derby WA 6728 Tel: 08 9193 1633</p>	<ul style="list-style-type: none"> • Derby and surrounds • Fitzroy Crossing • Other communities as required
<p><i>Kununurra</i> 96 Coolibah Drive, Kununurra WA 6743 Tel: 08 9166 4350</p>	<ul style="list-style-type: none"> • Kununurra and surrounds • Hall's Creek • Balgo Hills • Wyndham • Oombulgurri • Kalumburu • Other communities as required

Pilbara Mental Health and Drug Service (PMHDS)

<p><i>Port Hedland</i> Sutherland Street Tel: 9158 1400 Fax: 9173 2340</p>	<ul style="list-style-type: none"> • Port Hedland and surrounds • Punmu • Kunawarditj • Marble Bar • Yande Yarra • Other communities as required
<p><i>Karratha</i> Nickol Bay Hospital Millstream Road Karratha W.A 6714 Tel: 9143 2346 Fax: 9143 2391</p>	<ul style="list-style-type: none"> • Karratha and surrounds • Panawonica • Roebourne • Other communities as required
<p><i>Newman</i> Newman Community Health Mandarra Street Newman, WA 6753 Tel: 9175 8340 Fax: 9175 8280</p>	<ul style="list-style-type: none"> • Newman and surrounds • Cotton Creek • Jigalong • Other communities as required
<p><i>Tom Price</i> Tom Price Hospital Mine Road Tom Price WA 6751 Tel: 9159 5282 Fax: 9189 3177</p>	<ul style="list-style-type: none"> • Tom Price • Paraburdoo • Wakathunia Community • Belaire Springs Community • Other communities as required

Central West Mental Health Service (CWMHS)

<p><i>Geraldton</i> 51-85 Shenton Street Geraldton WA 6530 Tel: 08 9956 1999</p>	<ul style="list-style-type: none"> • Geraldton and surrounds • Morawa • Eneabba • Three Springs • Carnamah • Perenjori • Dongara / Port Denison • Coorow • Mingenew • Leeman • Mullewa • Yalgoo • Kalbarri • Northampton
<p>Gascoyne <i>Carnarvon</i> 5 Stuart Street Carnarvon WA 6701 Tel: 9941 6600 <i>Exmouth</i> Exmouth Hospital Lyon Street Exmouth WA 6707 Tel: 9949 2584</p>	<ul style="list-style-type: none"> • Carnarvon and surrounds • Burringurrah • Denham • Shark Bay • Exmouth and surrounds • Onslow • Coral Bay
<p><i>Meekatharra</i> Savage Street Meekatharra WA 6642 Tel: 08 9981 0625</p>	<ul style="list-style-type: none"> • Mount magnet • Cue • Sandstone • Wiluna

Wheatbelt Mental Health Service (WMHS)

<p><i>Northam</i> U10/210 Fitzgerald St Northam WA 6401 Tel: 96210999</p>	<ul style="list-style-type: none"> • Avon Valley, • Central Wheatbelt, • part Western Wheatbelt and surrounds
<p><i>Merredin</i> Old Doctors Surgery Haig St Merredin WA 6415</p>	<ul style="list-style-type: none"> • Merredin • Eastern Wheatbelt
<p><i>Gingin</i> U2 Gingin Business Centre Brockman Rd Gingin WA 6503</p>	<ul style="list-style-type: none"> • Coastal strip, • Chittering valley • part Western Wheatbelt

Goldfields Mental Health Service (GMHS)

<i>Kalgoorlie Inpatient Service</i>	<ul style="list-style-type: none"> • Inpatient Mental Health Service. Ward based within the Kalgoorlie Health campus
<p><i>Kalgoorlie</i> Kalgoorlie Hospital Cnr Maritana and Piccadilly Street, Kalgoorlie WA 6430 Tel: 08 9088 6200</p>	<ul style="list-style-type: none"> • Kalgoorlie-Boulder • Coolgardie • Kambalda • Leonora • Laverton • Menzies
<p><i>Esperance</i> Forrest Street, Esperance WA 6450 Tel: 08 9071 0444</p>	<ul style="list-style-type: none"> • Esperance • Norseman • Ravensthorpe • Hopetown

South West Mental Health Service (SWMHS)

<p><i>Bunbury Acute Psychiatric Unit</i> Southwest Health Campus Robertson Drive, Bunbury WA 6230 Tel: 9722 1300</p>	<ul style="list-style-type: none"> • Psychiatric Intensive Care Unit • Statewide provider of Inpatient mental health services • 7 secure beds • 20 open ward beds
Upper South West	
<p><i>Bunbury</i> Southwest Health Campus Robertson Drive, Bunbury WA 6230 Tel: 9722 1300</p>	<p>2 teams</p> <ul style="list-style-type: none"> • Australind/Eaton, Collie, Harvey and surrounds • Bunbury, Capel, Donnybrook and surrounds
<p><i>Stepping Stones</i> 27 Strickland Street Bunbury WA 6230 Tel: 9791 4729</p>	<ul style="list-style-type: none"> • Rehab service to Upper south west
Lower South West	
<p><i>Busselton</i> 18 West St Busselton WA 6280 Tel: 97540560</p>	<ul style="list-style-type: none"> • Busselton, • Dunsborough, • Yallingup and surrounds
<p><i>Bridgetown</i> 88b Hampton Rd Bridgetown WA Tel: 97612644</p>	<ul style="list-style-type: none"> • South from Balingup to Bridgetown, Manjimup, Pemberton, Nannup
<p><i>Margaret River</i> U3/18 Fearn Ave Margaret River WA 6285</p>	<ul style="list-style-type: none"> • Margaret River, • Metricup, • Willyabrup • Cowaramup, • Witchcliffe, • Augusta,

Great Southern Mental Health Service (GSMHS)

<p><i>Albany Inpatient Service</i> Albany Regional Hospital Hardie Street Albany WA 6330 Tel: 9892 2525</p>	<ul style="list-style-type: none"> • Inpatient Mental Health Service. Ward based within the Albany Regional Hospital
<p><i>Albany</i> Cnr Hardie Street & Warden Avenue Albany WA 6330 Tel: 08 9892 2440</p>	<ul style="list-style-type: none"> • Albany and surrounds • Denmark • Mt Barker • Jerramungup
<p><i>Katanning</i> Francis Street, Katanning WA 6317 Tel: 08 9</p>	<ul style="list-style-type: none"> • Katanning and surrounds • Kojonup • Gnowangerup
<p><i>Narrogin</i> Williams Road, Narrogin WA 6312 Tel: 08 9881 0700</p>	<ul style="list-style-type: none"> • Narrogin and surrounds • Wagin • Boddington • Lake Grace • Kondinin

Appendix 2: WACHS Current Service Planning and capital projects that impact on Mental Health Services

Project Phases	Lead Agency	Capital Projects that impact on Mental Health Services
Proposal/Concept Plan	WACHS	<p><u>Regional</u></p> <ul style="list-style-type: none"> • Midwest <ul style="list-style-type: none"> ○ Geraldton redevelopment including APU and ED ○ Exmouth health centre upgrade <p><u>Area Wide</u></p> <ul style="list-style-type: none"> • WACHS Drug and Alcohol Plan • Aboriginal clinic upgrades
Service Planning	WACHS	<p><u>Regional/District Service Planning that impacts on mental health services</u></p> <ul style="list-style-type: none"> • Kimberley: <ul style="list-style-type: none"> ○ Kununurra ○ Kutjunka region • Pilbara: <ul style="list-style-type: none"> ○ Karratha – Nickol Bay Health campus ○ All other West and East Pilbara hospitals excl Port Hedland • Goldfields - Esperance redevelopment including ED and comm. MH • Midwest - Carnarvon redevelopment including ED • Wheatbelt - including redevelopments at Narrogin and Merredin incl ED • SW - Harvey hospital upgrade incl ED • SW - Busselton service planning <p><u>Area Wide Services Planning</u> Mental Health including mental health promotion</p>
Functional Brief	BMW with input from WACHS	<ul style="list-style-type: none"> • Bunbury ED and Critical Care
Master Planning	BMW with	<ul style="list-style-type: none"> • Albany redevelopment

Project Phases	Lead Agency	Capital Projects that impact on Mental Health Services
/Design documentation	input from WACHS	
Tender/Construction/Commissioning	BMW	<ul style="list-style-type: none"> • Kalgoorlie redevelopment including ED – construction underway • Broome APU – construction due to commence • Port Hedland (commissioning due Oct 2010) • Wyndham upgrade – commissioned • Denmark - commissioned

Appendix 3: Strategic Mental Health Documents

1. Fourth National Mental Health Plan 2009 – 2014
2. The Mental Health Statement of Rights and Responsibilities (1991);
3. National Mental Health Standards (currently in the final stages of review);
4. National Practice Standards for the Mental Health Workforce (2002);
5. Promotion Prevention and Early Intervention (2000);
6. National Mental Health Policy (2008);
7. National Safety Priorities in Mental Health (2005);
8. COAG National Action Plan on Mental Health (2006-2011).
9. WA Mental Health Strategy 2004 – 2007;
10. Partnerships Create Good Outcomes (Western Australia's Mental Health Future Directions 2004 – 2008);
11. Western Australian Suicide Prevention Strategy 2009 – 2013: Everybody's Business